

# *Rhode Island* **MEDICAL JOURNAL**

**JUNE 1945**



*Fourth Annual*

**CHARLES V. CHAPIN ORATION**

**"SOME RECENT ADVANCES IN THE CONTROL  
OF INFECTIOUS DISEASES"**

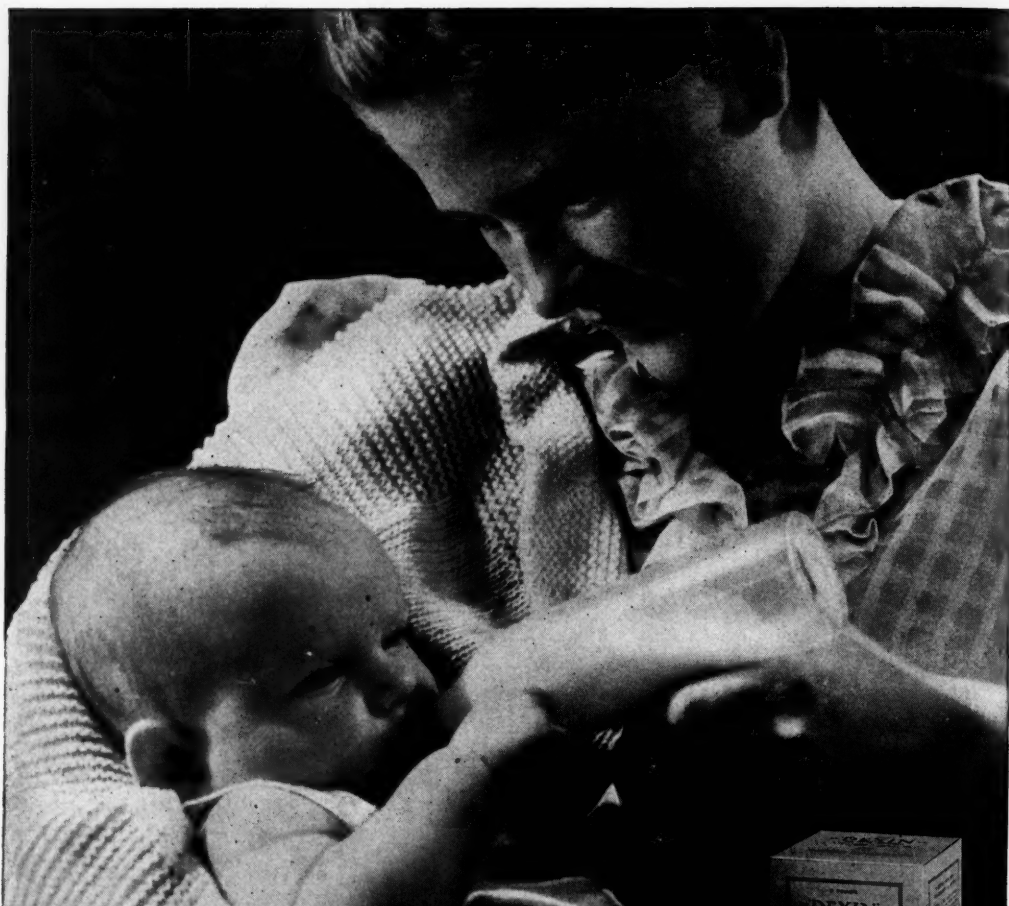
**Page 409**

**Volume XXVIII, No. 6**

**Contents Page 403**

---

**THE RHODE ISLAND MEDICAL SOCIETY  
THE RHODE ISLAND DENTAL SOCIETY  
HOSPITAL ASSOCIATION OF RHODE ISLAND**



## *Forming good habits early*

Mother has the satisfaction of knowing that making 'Dexin' formulas for her baby helps to assure sound habits of eating, sleeping and elimination.

The baby regularly takes his full quota of palatable 'Dexin' feedings. They are not excessively sweet, and do not dull the appetite. Adding bland foods to the diet is more easily accomplished.

A well-fed 'Dexin' baby is not awakened by unsatisfied hunger. 'Dexin' helps eliminate disturbances that might interrupt sleep. Its high dextrin content (1) reduces intestinal fermentation and the tendency to colic, diarrhea and constipation, (2) promotes the formation of soft, flocculent, easily digested curds. 'Dexin' Reg. U. S. Pat. Off.



*'Dexin' does make a difference*

### COMPOSITION

Dextrins . . . . .	.75%	Mineral Ash . . . . .	0.25%
Maltose . . . . .	.24%	Moisture . . . . .	0.75%

Available carbohydrate 99% 115 calories per ounce  
6 level packed tablespoonfuls equal 1 ounce

# 'DEXIN'

HIGH DEXTRIN CARBOHYDRATE



Literature on request



**BURROUGHS WELLCOME & CO. (U.S.A.) INC.** 9-11 E. 41st St., New York 17, N. Y.



**H**YPERTENSION and its associated symptoms should not be allowed to run its course. A safe palliative that helps to check rising blood pressure is highly desirable in the management of this condition.

Anti-hypertensive medication requires the most careful consideration. There is ample evidence in the literature to show that the thiocyanates and the barbiturates are often dangerous and their frequent use ill-advised.

ALLIMIN is a safe, efficacious, anti-hypertensive, as repeatedly determined by extensive pharmacological and clinical research. ALLIMIN is free from toxicity. There are no known contraindications and no incompatibles. This makes it eminently suitable for long-continued use.

**FORMULA:** Enteric coated tablets containing 4.75 gr. dehydrated garlic concentrate and 2.37 gr. dehydrated parsley concentrate. Tasteless and odorless.

**DOSAGE:** Minimal dose is 2 tablets, with water, t.i.d., after meals. Intermittent courses, skipping every fourth day, recommended.

Available in packages of 60 and 250 tablets, ALLIMIN is advertised only to the medical profession. For physician's sample and covering literature, sign and mail the coupon.



**VAN PATTEN PHARMACEUTICAL CO.**

500 N. Dearborn St. Chicago 10 RIJM-6

Please send professional sample of ALLIMIN and covering literature and monograph on hypertension.

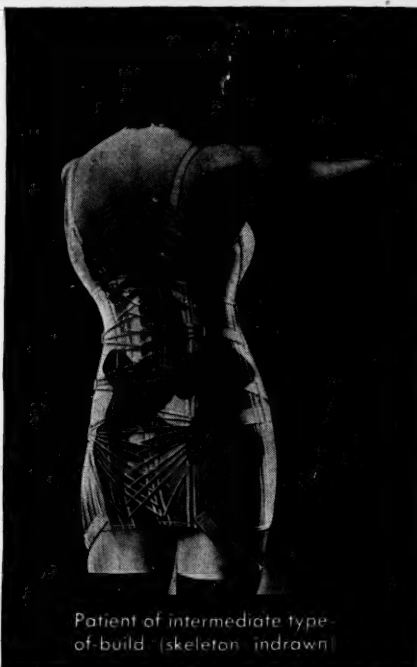
Dr. \_\_\_\_\_

Address \_\_\_\_\_

Town \_\_\_\_\_ State \_\_\_\_\_

**CAMP**  
**Orthopedic**  
**Support**  
 FOR  
**Chronic**  
**Low Back Pain**

This lumbosacral support is specifically designed to limit the range of the lumbar spine bending when either the framework or soft tissues of the low back are the seat of injury or disease. Effective support is given the gluteal region, the lumbar spine and the sacro-iliac and lumbo-sacral joints. The adjustment about the pelvic girdle prevents undue pressure of the upper adjustments and yet the presence of the center adjustment gives relief and comfort to the patient. Provision is made for reinforcement with aluminum uprights when indicated.



Patient of intermediate type of build (skeleton indrawn)



**CAMP**

**ANATOMICAL SUPPORTS**

Prescribed in many types for the condition illustrated and for Prenatal, Postnatal, Post-operative, Pendulous Abdomen, Visceroptosis, Nephroptosis, Hernia and Orthopedic conditions.

**S. H. CAMP & COMPANY**  
 Jackson, Michigan

*World's Largest Manufacturers of Scientific Supports*

Offices in NEW YORK • CHICAGO  
 WINDSOR, ONT. • LONDON, ENG.

*If you do not have a copy of our "Reference Book for Physicians and Surgeons", copy will be sent upon request.*



# The RHODE ISLAND MEDICAL JOURNAL

VOL. XXVIII

JUNE 1945

No. 6

## *The Fourth Annual Charles V. Chapin Oration*

### SOME RECENT ADVANCES IN THE CONTROL OF INFECTIOUS DISEASES\*

FRANCIS G. BLAKE, M.D.

---

The Author. *Francis G. Blake, M.D., of New Haven, Conn.; Dean and Sterling Professor of Medicine, Yale University School of Medicine; President, Army Epidemiological Board, Preventive Medicine Service, Office of the Surgeon General, U. S. Army.*

---

IT is a great honor and a privilege to have been invited to deliver the annual Charles Value Chapin Oration of the Rhode Island Medical Society. When George E. Vincent<sup>1</sup> addressed this Society in 1927 on the occasion of the testimonial exercises at the unveiling of Dr. Chapin's portrait he not only paid tribute to Dr. Chapin's devotion to the scientific method, to his outstanding contributions to the control of communicable disease and to his statesmanship in the broad field of public health, but also described in his felicitous way some of those qualities which made Dr. Chapin the great man that he was. Said Dr. Vincent, among many other things: "[Dr. Chapin] has such a terrible passion for presenting things just as they are"; and again "good team work . . . is one thing Dr. Chapin has made one of his hobbies . . .". And Dr. Place in his Charles V. Chapin Oration<sup>2</sup> two years ago appropriately singled out another characteristic of the man whom we honor this evening when he said, "Few men in the field of contagious diseases have been more alert to the changing views, or indeed have added more changes, than Dr. Chapin." A devotion to the scientific method, a passion for truth, a capacity for team work and an alertness to change, these are a group of qualities of which anyone might indeed be proud, but which Dr. Chapin in his characteristic modesty would have been the first to disclaim.

In selecting a subject for this address, then, it has naturally been my desire not only to choose one which would be appropriate for a talk which commemorates Dr. Chapin but also one which I hope may to some small extent be compatible with those qualities which so distinguished Dr. Chapin's

career. In my title I have used the word "control" rather than "prevention" or "treatment" since it would appear to be a broad enough term to encompass both, for the prevention and treatment of infectious diseases are inextricably interwoven to form a symmetrical whole, which should be of equal interest to the practicing physician and the worker in the field of public health. Here again Dr. Chapin's pragmatic approach was unsurpassed, I quote, "Whatever the medical profession can do better than the State the medical profession should do. Whatever the State or a group of private citizens can do better than the doctors, the State and private organizations should do, whether it is preventive or curative".

Advances in the control of infectious diseases during recent years are writing a brilliant chapter in the history of medicine. Soundly based on scientific research, conspicuously the product of cooperative research, stimulated no doubt by the urgent necessities of war, they are bringing changes in prevention and treatment which open new vistas in the struggle of man against the parasites which beset him, if I may plagiarize a catch phrase, from the womb to the tomb. So numerous are they that it would be quite impossible to do more than catalogue them if all were to be touched upon in the time at my disposal. Force of circumstance, then, compels me to select a few by way of illustration of the whole.

In making these selections I have been guided by a desire to illustrate the several methods of approach commonly used in the attempt to control communicable disease, namely: the production of a temporary passive immunity by the injection of humoral antibodies; the stimulation of an active and more lasting immunity by vaccination; the prevention of threatened infection by the mass administration of a suppressive agent to the whole of an endangered population; sanitary environmental control, in this instance in an effort to reduce the incidence of acute respiratory diseases; and finally the prompt treatment and cure of communicable

*continued on next page*

\*Presented at the 134th Annual Meeting of the Rhode Island Medical Society, at Providence, on May 16, 1945.

disease with antibiotics, a procedure which may serve not only to alleviate actual disease but also to prevent complications and sequelae as well as to reduce the chances of transmission of the infection to others.

The advances which I propose to discuss have originated from the work of numerous investigators and, as I have said, are conspicuously the product of cooperative research. In large part they have been sponsored and supported by the Board for the Investigation and Control of Influenza and Other Epidemic Diseases in the Army<sup>3</sup> or the Committee on Medical Research of the Office of Scientific Research and Development or both, through contracts with many of our Universities. The Army Epidemiological Board, as it is commonly called, was established on request of Surgeon General James C. Magee in January 1941 and has been in continuous operation since that time in the Preventive Medicine Service of The Surgeon General's Office in Washington under the stimulating guidance of Brig. Gen. James S. Simmons and the able administration of Brig. Gen. Stanhope Bayne-Jones. The central Board from the beginning has consisted of seven civilian consultants experienced in the field of infectious diseases: Dr. Francis G. Blake, President, Drs. Oswald T. Avery, Alphonse R. Dochez, Ernest W. Goodpasture, Kenneth F. Maxcy, O. H. Perry Pepper, and Andrew J. Warren. Operating under the Board are ten Commissions comprised of more than 100 civilian specialists in infectious diseases and 25 officers of the Army Medical Corps. These Commissions have been constantly engaged in both laboratory and field investigations in this country and overseas in an effort to advance knowledge about infectious diseases with the ultimate aim of improving methods of control. In a similar fashion and with the same aims in view, the Committee on Medical Research under the Chairmanship of Dr. A. N. Richards and with the advisory assistance of appropriate committees of the Division of Medical Sciences of the National Research Council has directed a part of its many activities toward the solution of problems of infection, particularly those of importance to our Armed Forces in the prosecution of the war. As in the case of the Army Epidemiological Board these have been cooperative undertakings in which numerous investigators have pooled their interests and collaborated effectively. When suitable opportunities arose the two organizations have joined in an effort to expedite the problems under investigation.

So much by way of introduction. Let us turn now to a consideration of some of the advances that have been made.

### *Control by Passive Immunization Measles and Infectious Hepatitis*

Two advances in the prevention of infectious diseases by the establishment of a temporary passive immunity in exposed susceptible individuals will be cited. The first, in the case of measles, represents an improvement in method, the second in the case of infectious hepatitis, a new and original observation.

Appropriately enough for this occasion you will recall that one of your own distinguished physicians here in Providence, Dr. D. L. Richardson<sup>4</sup> successfully initiated passive immunization against measles with convalescent measles serum and presented a paper on this subject before this society on March 7, 1919. In that paper Dr. Richardson stated, "The attempt at immunization against this disease was suggested by Dr. Charles V. Chapin", and he concluded with commendable caution that, "The experiments are too few to be conclusive, but they are sufficiently suggestive to warrant further investigation."

Subsequent experience during the ensuing quarter of a century has served fully to confirm Dr. Richardson's original observation as shown by the data compiled from the literature by McKhann<sup>5</sup>. Of 1627 cases receiving convalescent serum, unselected with respect to dosage or time after exposure when serum was injected, 75 per cent were fully protected, 17 per cent were partially protected, the measles which occurred being attenuated, while only 8 per cent came down with unmodified measles. Similar, though somewhat less satisfactory results have been obtained with pooled adult serum and globulin derived from human placentas.

With the background of these observations as a starting point it seemed probable that the concentrated preparations of serum globulins, which had become available through the work of Cohn, Oncley, Strong, Hughes and Armstrong<sup>6</sup> on the fractionation of pooled human plasma and which had been shown by Enders<sup>7</sup> to contain a variety of antibodies in concentrated form, particularly in fraction II containing the gamma globulins, should be useful for preventing or attenuating measles. Consequently Stokes, Maris and Gellis of the Commission on Measles and Mumps of the Army Epidemiological Board and Ordman, Jennings and Janeway for the Committee on Medical Research undertook studies to determine whether this supposition might be true and have recently reported the results of their observations<sup>8,9</sup>. It was found by both that concentrated normal human serum gamma globulin was highly effective in preventing or attenuating measles, that no significant untoward reactions were observed in any of the inoculated cases, that a dosage of 2.5 cc. in smaller children

and 5.0 cc. in older children was adequate for protection in most instances, if the injection was given within the first five days after exposure, but that from the sixth day onward the percentage of attenuated cases and failures increased. To cite but one example from these studies Ordman, Jennings and Janeway<sup>9</sup> report that in a controlled group of cases with intimate family exposure protection was afforded in 71 per cent and attenuation in 27 per cent with only a 2 per cent failure among 62 inoculated children, while among 46 uninoculated controls 89 per cent developed measles of average severity, 4 per cent had mild measles and only 7 per cent failed to contract the disease. The use of normal human gamma globulin for the prevention or attenuation of measles would appear to be a distinct advance since it offers the definite advantages of being readily produced from an abundant source of supply, it is effective in small doses, and its administration is devoid of significant local or general reactions.

Epidemic catarrhal jaundice or infectious hepatitis, as it is now commonly called, has long been recognized as a clinical entity occurring in epidemic outbreaks in this country and abroad, particularly in schools or similar institutional groups. Until quite recently, however, its etiology and method of transmission have been quite unknown, and no method of prevention or specific treatment has been available. With this war, as in previous wars, epidemics of infectious hepatitis have become a problem of military importance<sup>10, 11</sup>. As a result a great deal of work has been directed toward the discovery of the etiological agent and the elucidation of the mode of transmission. Through the studies of MacCallum and Bradley<sup>12</sup>, Havens, Ward, Drill and Paul<sup>13</sup>, and of others, which it is not our purpose to review here, it has been shown that the disease can be readily transmitted to human volunteers by an agent present in the blood serum and feces of patients with the disease, either by injection or by feeding of the infective material. As in homologous serum jaundice and post-vaccinal jaundice (Oliphant<sup>14</sup>) the agent of infectious hepatitis is filtrable, withstands heating to 56°C. for 30 minutes and can be transmitted in serial passage in human volunteers (Havens<sup>15</sup>). While these two icterogenic agents or viruses possess some characteristics in common the relationship between them is not yet clear.

Of particular interest for the present discussion is the original observation of Stokes and Neefe<sup>16</sup> of the Commission on Measles and Mumps of the Army Epidemiological Board that concentrated gamma globulin<sup>6</sup> may be effective in the control of epidemics of infectious hepatitis. In a well controlled study of the protective value of gamma globulin in an extensive epidemic of infectious

hepatitis which occurred in a summer camp during August and September 1944, the overall incidence of hepatitis was 20.8 per cent in 53 subjects injected intramuscularly with globulin in an arbitrary dosage of 0.15 cc. per pound of body weight, 67.0 per cent in 278 uninjected controls. Further analysis showed that only 3 of the 11 injected subjects who contracted hepatitis or 27.3 per cent developed jaundice, which was only a mild scleral icterus of four to seven days duration, while 125 or 67.6 per cent of the 185 controls who developed hepatitis became jaundiced. Furthermore the onset of hepatitis in the 11 persons who received gamma globulin occurred during the first ten days after the injection, while cases continued to appear among the controls for thirty-two days, a result which suggested that the administration of gamma globulin late in the incubation period brought about attenuation rather than prevention of the disease. The outcome of this experiment is statistically significant and in the words of the authors warrants further trial of gamma globulin as a means of controlling epidemics of infectious hepatitis. In fact confirmation is already at hand through a recent similar study of an epidemic of hepatitis in an orphanage by Paul<sup>17</sup> and Havens of the Commission on Neurotropic Virus Diseases of the Army Epidemiological Board, the results of which have not yet been published.

The use of gamma globulin for the prevention or attenuation of epidemic infectious hepatitis would appear to be a real advance in the control of a hitherto uncontrollable disease sufficiently promising to warrant further trial when opportunity arises in order that its usefulness may be exactly defined under varying circumstances.

#### *Control by Active Immunization Influenza*

Active immunization against infectious diseases by inoculation with an appropriate antigen, whether a vaccine or a toxoid, is a well established procedure which has proved more or less effective in a variety of diseases such as smallpox, diphtheria, typhoid fever, tetanus, yellow fever, rabies, and epidemic louse-borne typhus.

Although many efforts had been made prior to 1941 to develop an effective vaccine against epidemic influenza, no definite answer to the essential question of whether effective prophylaxis against influenza was obtainable was at hand at that time. Consequently, one of the first tasks which the Army Epidemiological Board undertook through its Commission on Influenza under the direction of Dr. Thomas Francis, Jr., was a solution of this problem. The results which have been obtained to date would appear to have provided a sufficiently

*continued on next page*

definite answer to have placed the control of influenza, at least epidemic influenza A and perhaps influenza B, well within the realm of possibility if not of probability.

In 1942 Francis and Salk<sup>18</sup> devised a simplified method for the preparation of a concentrated and purified influenza virus vaccine based upon the observations of Hirst<sup>19</sup> that influenza virus grown in the chorioallantoic fluid of the chick embryo can be adsorbed by the erythrocytes of the embryo and then readily eluted from the red blood cells. Each 1.0 cc. of the finished vaccine which was inactivated with formaldehyde, contained the amount of Type A virus (PR 8 and Weiss strains in equal parts) recovered from 5.0 cc. of allantoic fluid, and the amount of Type B virus (Lee strain) recovered from an equivalent amount of allantoic fluid. This vaccine was then demonstrated to be capable not only of stimulating the production of antibodies and actively immunizing mice, but also of furnishing definite protection in human beings against experimental induction of influenza A<sup>20</sup> and influenza B<sup>21</sup>.

Based on the foregoing results and with the expectation that there might be an epidemic of influenza during the 1943-44 respiratory disease season, a plan was drawn up and preparations made through Preventive Medicine Service, Office of the Surgeon General for the Commission on Influenza to test the efficacy of the vaccine in a well controlled study in Army Specialized Training Program units in eight universities in different parts of the country and in five New York medical and dental schools. The nine groups comprised 12,474 men of which 6,263 were injected subcutaneously with a single dose of 1.0 cc. of the vaccine, while 6,211 alternate controls received an inert injection of similar volume. The vaccination was carried out during the fall of 1943 and was in the main completed by the middle of November. Fortunately for the experiment an epidemic of influenza began during the latter half of November, reached its peak in the first half of December, and then promptly subsided. This outbreak of influenza was promptly detected in Michigan<sup>22</sup> and Minnesota<sup>23</sup>, quickly shown to be due to Type A influenza virus, and all units were immediately notified. Careful clinical observations were made throughout the epidemic and all diagnoses recorded without knowledge of whether the individual diagnosed as having influenza was in the vaccinated or control group. The individual group and overall results have been published in a preliminary report<sup>24</sup> and may be summarized briefly as follows: vaccination with a single subcutaneous injection of 1.0 cc. of a concentrated inactivated influenza vaccine done shortly before or even after the onset of the influenza Type A epidemic of 1943 exerted

a marked though not complete protective effect with a total attack rate of 2.22 per cent among the 6,263 vaccinated persons as compared with an attack rate of 7.11 per cent in a rigidly comparable group of 6,211 controls. In other words 76.2 per cent of the cases of influenza occurred among the controls, only 23.8 per cent among the vaccinated. In one group in which vaccination was not done until the epidemic had been under way for 12 days, the protective effect of the vaccination became apparent about one week following the vaccination at which time there was a sharp drop in incidence in the vaccinated group as compared with a continued precipitous rise among the controls.

While the data from this study do not furnish final conclusions concerning all problems, such as the duration of immunity following vaccination nor the best ultimate method of vaccinating and best type of vaccine, they have shown clearly for the first time that vaccination shortly before an epidemic exerts a pronounced effect upon susceptibility to influenza A during an epidemic of high incidence.

These additional problems are now under investigation in an effort to determine whether a more effective concentrated and purified vaccine can be prepared by ultracentrifugation according to the methods described by Beard<sup>25</sup> and by Stanley<sup>26</sup>, whether a modification of the dosage schedule may increase or prolong the period of immunity, and what the duration of immunity may be. Whether the advance which has already been made in the control of epidemic influenza A will be equally effective in influenza B or effective at all in severe pandemic influenza remains to be determined.

#### *Prevention of Threatened Infection by Mass Administration of a Suppressive Agent Meningococcal Meningitis*

In the Charles V. Chapin Oration of two years ago Dr. Place<sup>2</sup> stated: "With our present data, it is obvious that any attempt to control sources of [Meningococcus] infection would have to go beyond the patients with recognizable symptoms or even their known immediate contacts and include a large proportion of population . . . . It is not improbable with the growing knowledge of efficient means of carrier cure that the present [tendency to ignore the carriers] may again be reversed." This prophetic suggestion was already being submitted to experimental investigation by Mueller<sup>27</sup>, and Phair and Schoenbach<sup>28, 29</sup> of the Commissions on Epidemiological Survey and Meningococcal Meningitis, respectively, of the Army Epidemiological Board, and by Kuhns, Nelson, Feldman and Kuhn<sup>30</sup> in a controlled field trial at an Army post during the epidemic of meningococcal meningitis during the first half of 1943.



For these studies sulfadiazine was selected because of its known effectiveness in the treatment of meningococcal meningitis as the most suitable mass prophylactic agent for trial in an effort to determine whether meningococci could be promptly eliminated from the nasopharynx of carriers as a means of checking the spread of meningitis during epidemic outbreaks of the disease. All three groups of investigators were able to show that sulfadiazine was highly effective in promptly curing the carrier state. Phair and Schoenbach<sup>29</sup> in a series of carefully controlled studies demonstrated that a single dose of 2.0 grams of sulfadiazine given orally was the minimal effective dose and was equally active for Group I, Group II, and Type IIa meningococci. Parasitic cure was obtained in 95 to 100 per cent of the carriers or "subclinical infections", as Phair prefers to call them, within 24 to 48 hours. Kuhns<sup>30</sup> and his collaborators used 3.0 grams daily for 3 days in one experiment and 2.0 grams daily for 2 days in another and found the smaller dosage as effective as the larger in eliminating carriers and stopping the epidemic in the treated group. Mueller<sup>27</sup>, on the other hand, feels that the larger dosage and more prolonged treatment is desirable if the best results are to be obtained.

It may be concluded from these studies that in relatively isolated groups of individuals the mass prophylactic administration of sulfadiazine to all members of the group is a feasible and effective method for rapidly decreasing the prevalence of meningococcal infections in the group but that further experience is necessary to determine the most suitable dosage for terminating an epidemic. A word of caution is necessary, however, particularly with respect to epidemic meningitis in the general population, for, as pointed out by Phair<sup>31</sup>, a single mass prophylactic administration of sulfadiazine obviously cannot control the incidence of reacquisition of subclinical infections indefinitely. By this procedure only immediate parasitic suppression is attained and there is no ground for the assumption that the sulfonamides confer freedom from, or enhance resistance to subsequent infection over any long period of time if members of the treated group mingle with an untreated group with a higher carrier rate. The rapidity with which the treated groups will attain the prevalence level of the general community in the post sulfonamide period will depend upon the degree of re-exposure. Although mass prophylaxis with sulfadiazine is a distinct advance in the control of epidemic meningitis, its utilization for the suppression of country-wide epidemics in the civilian population is beset with practical difficulties and has obvious limitations. Nevertheless it might seem wise in the case of a community outbreak to give mass sulfadiazine prophylaxis to all members of the community every

three weeks until the epidemic period has passed.

Another example of research on the prevention or suppression of threatened infection by mass administration of a suppressive agent, such as the attempted control of hemolytic streptococcal infections by the daily administration of small doses of sulfadiazine during the respiratory disease season<sup>32</sup>, may be cited but cannot be discussed in detail for want of time. In brief it may be said of sulfadiazine prophylaxis of hemolytic streptococcal respiratory infections that, although considerable evidence in support of its effectiveness has been accumulated<sup>32</sup>, recent experience with the appearance of sulfonamide resistant strains of streptococci, possibly as an evolutionary selective development of the widespread use of sulfonamides, has introduced a note of warning with respect to the general application of this procedure. Limited trial in serious institutional epidemics, on the other hand, may be justified, at least until the possible benefits and possible dangers have been more thoroughly assessed.

A further well known example is the successful suppression of the clinical manifestations of malaria by the continuous administration of atabrine to those exposed to the bites of infected mosquitoes. Although many important advances have been made in defining the proper application of this procedure and in reducing non-effectiveness from malaria, atabrine does not prevent infection with *Plasmodium vivax* and the search for a true preventive continues<sup>33</sup>. Information concerning this work, which is being carried on under the auspices of the Committee on Medical Research of the Office of Scientific Research and Development is restricted in the interests of national safety and cannot be discussed at this time.

#### *Sanitary Environmental Control Acute Respiratory Diseases*

The success which has been achieved by sanitary science in the control of water-, milk-, food- and insect-borne diseases has no parallel up to the present in the sanitary control of acute respiratory disease. In fact and irrespective of whether the acute respiratory diseases are contact, air-borne, droplet or dust-borne infections, their general control by sanitary measures has seemed until quite recently to be an almost insurmountable problem, so long as man lives in intimate daily contact with his fellows and must breathe to live. Yet despite the apparent hopelessness of the problem, much has been accomplished in the control of hospital cross infection, as recently set forth in an excellent historical review of the subject by Cruickshank<sup>34</sup>, and a beginning has been made which may perhaps lead eventually to some measure of control of wider application.

*continued on next page*

I shall discuss briefly here only two procedures, one initiated by Robertson, Bigg, Miller and Baker<sup>35</sup> and both later carried forward by Robertson and his collaborators. Puck, Loosli, Lemon, Wise and Hamburger<sup>41</sup> of the Commission on Air-Borne Infections of the Army Epidemiological Board with additional support from the Committee on Medical Research, namely, — the sterilization of air with glycol vapors and the oiling of floors and bed clothes.

Robertson<sup>36</sup> summarized the basic work on sterilization of air with glycol vapors in his Harvey Lecture of April 1943. In brief propylene glycol in a concentration of one gram in 5 million to 10 million cc. of air, and triethylene glycol in a concentration of one gram to several hundred million cc. of air were found to be lethal within seconds to minutes, depending on the concentration and the kind of glycol, for the common respiratory pathogens including pneumococci, hemolytic streptococci, *H. influenzae*, *H. pertussis* and the virus of influenza. The vapor affected the air-suspended organisms through abundant collisions between the hygroscopic glycol molecules and the bacteria- or virus-containing droplets. Desiccated bacterial particles on the other hand were not as susceptible to the vapor action as moist ones and the glycols were most effective at relative humidities between 40 and 60 per cent. No deleterious effects were found in rats and monkeys from prolonged inhalation of glycol vapor for periods up to eighteen months.

The engineering problems involved in the practical application of these findings have been under investigation during the past two years and would appear to be nearing solution<sup>37</sup> so that practical tests of the value of glycol vapor in reducing the incidence of respiratory infections, which are extremely meagre at present, may be instituted.

Numerous studies during recent years have shown that not only the air but also floor dust and bedding may be heavily contaminated with hemolytic streptococci in indoor environments where carriers of hemolytic streptococci or those sick with streptococcal infections are housed<sup>34, 38</sup>. The control of these latter sources for the dissemination of bacteria as a supplement to the use of aerosols would appear to be an important aspect of the attempt to control air-borne infection. In 1940, Van den Ende, Lush, and Edward<sup>39</sup> showed that the control of contaminated floor dust may be easily accomplished in barracks by means of oiling, but that on smooth floors of hospital wards it was necessary to use mopping or a special floor compound. The problem of treatment of bedding to prevent liberation of bacteria, first investigated by Thomas and Van den Ende<sup>40</sup>, has recently been solved by the Commission on Air-Borne Infections<sup>41</sup> through the

development of a practical and inexpensive oiling procedure for blankets and bed linen. Preliminary studies have shown that by a combination of floor oiling and the oiling of bed clothing the large numbers of hemolytic streptococci recoverable from the bedding and the air of heavily contaminated barracks can be markedly reduced and that by a combination of the oiling procedures with triethylene glycol vapor a reduction of 90 per cent or more may be promptly attained in hospital wards.

What the actual effectiveness of these sanitary methods may be in controlling respiratory infections remains to be determined by much further study under properly controlled experimental conditions. While it seems not at all improbable that they may prove to be of considerable value among hospital and other institutional populations, their more general utility would appear *a priori* to be limited by the fact that much transmission of respiratory infection presumably occurs under situations in which they could not be used.

#### *Treatment of Communicable Disease with Antibiotics* *Syphilis*

The remarkable advance which has occurred in the control of numerous infectious diseases through the introduction of sulfonamides and more recently of penicillin is too broad and familiar a subject to warrant a general discussion. It would seem neglectful, however, if a few words were not said about the treatment of early syphilis with penicillin, for this may well prove to be one of the more important advances of the day. Two years ago Mahoney, Arnold and Harris<sup>42</sup> of the Venereal Disease Research Laboratory and the United States Marine Hospital on Staten Island, N. Y., undertook an exploration of the influence of penicillin therapy on the clinical manifestations and serologic reactions of four patients with primary syphilis, all of whom displayed darkfield positive lesions. All four experienced a rapid healing of the primary lesions, which became promptly darkfield negative, and all attained sero-negativity within three months. As a result of these observations a cooperative study of the effect of penicillin in syphilis in human beings was organized in September 1943 under the general auspices of the Committee on Medical Research and the specific direction of a Penicillin Panel appointed by the Subcommittee on Venereal Disease, National Research Council. Participating in the study are a large group of Army, Navy, U. S. Public Health Service and civilian hospital clinics. While the final results of this study obviously cannot be available for some time to come, a preliminary analysis by Moore, Mahoney, Schwartz, Sterberg and Wood<sup>43</sup> of the results obtained in 1,418 cases of early primary and secondary syphilis treated with several differ-



ent dosage schedules appears to have established the following points: (1) penicillin has a profound immediate effect especially in primary but also in early secondary syphilis with respect to rapid disappearance within less than 24 hours of surface *Treponema pallidum* from open lesions and the rapid healing of lesions; (2) serological reversal ensues within the following 3 to 6 months in the majority of cases; (3) the incidence of subsequent serological or clinical relapse bears a direct relationship to the total dosage given; (4) the optimum time-dose relationship of penicillin in early syphilis and the possible advantage of combined therapy with mapharsen is not yet established but it would already appear that the minimum dose, especially in secondary syphilis, should not be less than 20,000 units intramuscularly every 3 hours for 7½ to 10 days, or a total of 1,200,000 to 1,600,000 units. (5) Herxheimer reactions are frequent but not serious and other reactions are negligible.

Our own experience in the treatment of 80 cases at the New Haven Hospital would lead us to agree with these tentative conclusions, but we would like to suggest on the basis of the first 12 cases treated with 10,000 units every 2 hours for 8 days, before we joined the cooperative study which required a 3 hour interval, that the maintenance of a constantly higher blood level of penicillin than can be attained by a 3 hour interval schedule may be advantageous.

Whatever the ultimate place of penicillin may be in the treatment of syphilis, the mere fact that practically all cases of early syphilis receiving therapy can be promptly rendered non-infectious and will receive a full course of treatment in a brief time without the risks associated with massive arsenotherapy may be accepted as a significant advance in the control of venereal disease.

In the course of this discourse a number of illustrative examples of recent progress in the control of infectious diseases have been cited. There are many others already made or in the making, such as the new repellants and insecticides for the control of insect-borne diseases<sup>44</sup>, too numerous to be touched upon here. Suffice it to say by way of conclusion that our knowledge about many of them, as well as the subjects which have been discussed, is still fragmentary but this need not disturb us so long as progress continues to be made. Much that may seem sound and promising today will doubtless be modified or even discarded tomorrow through further experiment, but of this, as Dr. Chapin once said, "We should not be ashamed . . ." nor need we be, so long as we "keep an open but not an empty mind";<sup>2</sup> so long as we remain alert to the advances which scientific research provides but are not too hasty and uncritical in the application of new discoveries, until their validity be well established.

## REFERENCES

- <sup>1</sup>Vincent, G. E. Testimonial exercises, Rhode Island Med. J. 10: 33, 1927.
- <sup>2</sup>Place, E. H. Changing views of contagious diseases, Rhode Island Med. J. 26: 115, 1943.
- <sup>3</sup>Bayne-Jones, S. Board for the Investigation and Control of Influenza and Other Epidemic Diseases in the Army, Army Med. Bull. No. 64: 1, Oct. 1942.
- <sup>4</sup>Richardson, D. L., and Connor, H. Immunization against measles, J. A. M. A. 72: 1046, 1919.
- <sup>5</sup>McKhann, C. F. The prevention and modification of measles. J. A. M. A. 109: 2034, 1937.
- <sup>6</sup>Cohn, E. J., Oncley, J. L., Strong, L. E., Hughes, W. L., Jr., and Armstrong, S. H., Jr. The characterization of protein fractions of human plasma. J. Clin. Invest. 23: 417, 1944.
- <sup>7</sup>Enders, J. F. The concentration of certain antibodies in globulin fractions derived from human blood plasma. J. Clin. Invest. 23: 510, 1944.
- <sup>8</sup>Stokes, J., Jr., Maris, E. P. and Gellis, S. S. The use of concentrated normal human serum gamma globulin (human immune serum globulin) in the prophylaxis and treatment of measles. J. Clin. Invest. 23: 531, 1944.
- <sup>9</sup>Ordman, C. W., Jennings, C. G., Jr., and Janeway, C. A. The use of concentrated normal human serum gamma globulin (human immune serum globulin) in the prevention and attenuation of measles. J. Clin. Invest. 23: 541, 1944.
- <sup>10</sup>Witts, L. G. Some problems of infective hepatitis. Brit. M. J. 1: 739, 1944.
- <sup>11</sup>Havens, W. P., Jr., Infectious hepatitis in the Middle East. A clinical review of 200 cases seen in a military hospital. J. A. M. A. 126: 17, 1944.
- <sup>12</sup>MacCallum, F. O., and Bradley, W. H. Transmission of infective hepatitis to human volunteers. Lancet 2: 228, 1944.
- <sup>13</sup>Havens, W. P., Jr., Ward, R., Drill, V. A., and Paul, J. R. Experimental production of hepatitis by feeding icterogenic materials. Proc. Soc. Exp. Biol. & Med. 57: 206, 1944.
- <sup>14</sup>Oliphant, J. W. Jaundice following administration of human serum. The Harvey Lectures 39: 254, 1943-1944.
- <sup>15</sup>Havens, W. P., Jr. Properties of the etiologic agent of infectious hepatitis. Proc. Soc. Exp. Biol. & Med. 58: 203, 1945.
- <sup>16</sup>Stokes, J., Jr., and Neefe, J. R. The prevention and attenuation of infectious hepatitis by gamma globulin. Preliminary note. J. A. M. A. 127: 144, 1945.
- <sup>17</sup>Paul, J. R. Personal communication.
- <sup>18</sup>Francis, T., Jr., and Salk, J. E. A simplified procedure for the concentration and purification of influenza virus. Science 96: 499, 1942.
- <sup>19</sup>Hirst, G. K. The quantitative determination of influenza virus and antibodies by means of red cell agglutination. J. Exper. Med. 75: 47, 1942.
- <sup>20</sup>Francis, T., Jr., Salk, J. E., Pearson, H. E., and Brown, P. N. Protective effect of vaccination against induced influenza A. Proc. Soc. Exp. Biol. & Med. 55: 104, 1944.
- <sup>21</sup>Salk, J. E., Pearson, H. E., Brown, P. N., and Francis, T., Jr. Protective effect of vaccination against induced influenza B. Proc. Soc. Exp. Biol. & Med. 55: 106, 1944.
- <sup>22</sup>Salk, J. E., Menke, W. J., and Francis, T., Jr. Identification of influenza virus Type A in current outbreak of respiratory disease. J. A. M. A. 124: 93, 1944.
- <sup>23</sup>Rickard, E. R., Thigpen, M., and Crowley, J. H. The isolation of influenza A virus by the intra-allantoic inoculation of chick embryos with untreated throat-washings. J. Immunol. 49: 263, 1944.
- <sup>24</sup>Commission on Influenza. A clinical evaluation of vaccination against influenza. Preliminary report. J. A. M. A. 124: 982, 1944.
- <sup>25</sup>Taylor, A. R., Sharp, D. G., Beard, D., Beard, J. W., Dingle, J. H., and Feller, A. E. Isolation and characterization of influenza A virus (PR 8 strain). J. Immunol. 47: 261, 1943.

continued on page 421

## MEDICAL CARE IN RHODE ISLAND\*

ELIHU S. WING, M.D.

The Author, *Elihu S. Wing, M.D., of Providence, R. I.; President, Rhode Island Medical Society, 1944-45; Chief, Medical Service, Rhode Island Hospital.*

WE in Rhode Island seem to possess some advantages in living in the smallest state in the Union. One of these advantages is that our State Society was granted permission from Washington to hold its 134th annual session, and by virtue of this special dispensation we have had the privilege and real pleasure of listening to a series of scientific papers by authoritative physicians and surgeons from various medical centers in the East. These very busy doctors, I know, have come here at a sacrifice of time and strength. They have brought honor to us and our state and as a gesture of appreciation on our part I am asking that we all rise to a vote of thanks.

This matter of medical care, in its many phases, altered to fit changing social concepts, is a challenge to the medical profession. Whatever is done, the best elements in the science and art of medicine and its service to the people must be preserved and extended. Its quality must not be impaired but continue to improve.

Very properly, emphasis is being placed upon better distribution of medical facilities and care at lower costs. But along with this must go better education of the public relative to true medical values, knowledge of which creates the demand for these services.

It is my purpose under such a broad title to touch upon only some of the phases of the subject in relation to our situation here in Rhode Island, referring to present and future problems with certain suggestions. It is admitted that any sort of evaluation of medical conditions is abnormal in war time, yet there are many things which we can learn from performance under strain, especially our weaknesses.

Here I wish to thank all those who devoted precious time to answering questionnaires and letters of inquiry.

During the past three and a half years our civilian doctors have faced problems accentuated by a

\*Presidential Address delivered before the 134th Annual Meeting of the Rhode Island Medical Society, at Providence, May 17, 1945.

nation at war and in a period of growing social and economic change. We cannot claim to have successfully met all of our problems. Ours has been the humble task of work and long hours common to all who have labored to back up the war fronts. At the same time we physicians, like many others, are striving to preserve for ourselves and others in this country that "American Way of Life" which we so much cherish, and again for which so many of our young citizens have sacrificed in war their comforts of home or even given their lives. We are grateful to have been of essential service but regret that all we would desire to do has been impossible of fulfillment. That there have been medical needs not met, we know is true. Those seriously ill received first attention. While there were many instances of delay in response to calls, the inability of patients to get medical care was very infrequent in comparison with the multitudinous requests which were adequately covered.

#### *Distribution of Physicians*

In this state in 1940 we had 958 doctors including approximately 50 who were inactive. We now have, with 258 in military service, 600 active civilian physicians, nearly 200 of whom are over 60 years of age. Among the 600 are 19 released from active military service. It is significant to note that during these war years only eight physicians new to practice in Rhode Island are recorded, while 48 physicians have died, a great many of whom were on the active list.

The classification of these 600 civilian doctors reveals that approximately 54 are in full time work other than private practice. Some of these are in a specialty, but their work is confined to hospital, institutional or Government departments.

The population of Rhode Island at the present time as estimated by various state departments is 762,000, an increase over that given by the 1940 United States Census of nearly 50,000. The 1940 report gave 91.6% as urban and approximately 73% living in Providence County. The average physician-population ratio on the basis of 600 doctors and the 1945 population estimate is 1-1270 for the state; in Providence County 1-1100, but our larger hospitals are concentrated here and handle nearly 86% of all hospital admissions for acute illness. This indicates that Providence County

draws many hospital patients, not to mention physicians' office patients, from neighboring counties.

### Hospital Facilities

Hospital beds in Rhode Island are inadequate, especially those for the care of acute illnesses. (Chart 1). Nearly one-half of the hospital beds in the state are utilized for mental and nervous disorders. For the nation the average is about 51%.

Chart 1  
ALL CIVILIAN HOSPITAL BEDS IN RHODE ISLAND AND TYPES OF SERVICE

Type	Total Beds	General	Nervous & Mental	Tuberculosis	Maternity	Children	Isolation	Chronic Care
Private .....	2157	1443	224	60	430			
City .....	265		60	50			155	
State .....	4610		3000	618				992
Total .....	7032	1443	3284	728	430	592	[155]	992

This high incidence of mentally or nervously ill patients is and has been a challenge in preventive medicine or mental hygiene. Without question one of our acute and real problems today is that we have in this country but 4,500 psychiatrists and neurologists for the handling of a major task — and the situation will become more acute with growing numbers of war sick and weary veterans needing professional care. To bridge this dilemma means that we physicians who have developed in our practice some experience in the handling of such disorders must utilize this experience in practice, especially with many men leaving our military forces and in need of guidance.

To return to hospitals of our state, it is of more than passing interest to note the number of beds and admissions in our military hospitals. I am sure they are larger than we thought, especially the Newport Naval Hospital with 1400 beds. (Chart 2).

Chart 2  
MILITARY HOSPITALS IN RHODE ISLAND 1944

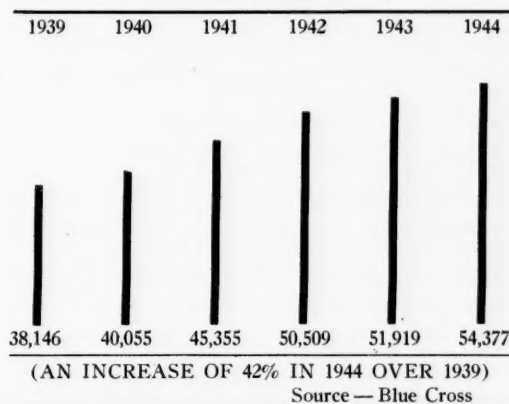
Service	Where Located	Type	No. Beds	Average Daily Pts.	Admissions
U. S. Navy	Davisville	General	550	350	9,091
U. S. Navy	Newport	General	1400	1050	
U. S. Navy	Quon. Pt.	General	308	180	1,635
U. S. Army	Newport	General	70	30	1,044
			2,328	1,610	20,419

Source A. M. A.

The hospitals for the care of our acutely ill (or the general private hospitals) show an admission increase of 42% since 1939, and many hospitals

have daily patient waiting admission lists up to — in one hospital — 600. The great majority of these are for surgery — necessary but not urgent cases. Emergencies have not fully been met, as three hospitals out of twelve report that there have been times when they were not able to meet this need. This doesn't necessarily mean that these emergencies were not taken care of, as they would of course be absorbed by other hospitals. (Chart 3).

Chart 3  
HOSPITAL ADMISSIONS —  
ACUTE ILLNESS IN RHODE ISLAND  
FOR 6 YEARS



At the present time some of our hospitals have closed wards or sections of private rooms due to a shortage of nurses, which averages approximately 35%. Furthermore, lack of unskilled labor has been a serious handicap to our hospitals.

In spite of all the handicaps, it seems incredible that the hospitals have not only long carried the heaviest load of patients in their histories, but major operations have increased in these hospitals from 22,000 in 1940 to 25,500 in 1944; and in the year 1943 those with maternity facilities took care of a 36% increase in births. This hospital burden has come at a time when the active medical staffs have been depleted by medical enlistment in the armed forces ranging from 20 to 45%.

This heavy hospital burden could not have been carried had it not been for the voluntary services rendered by those trained through the American Red Cross as well as hundreds of other volunteer workers serving in all manner of duties. The hospitals need many more of these civilian workers and especially Red Cross trained nurses' aides and dietitians and gray ladies. Practically every hospital stated that they were in need of more — some urgently so. Physicians and all others are urged to help stimulate more interest among those who can devote the time to this need — and particularly that they register for Red Cross training. This civilian hospital service is only a small part

continued on next page

of what this great institution is doing on the home front, not to mention their over-seas services.

The increasing demand for hospital beds over the past six years and inadequate facilities have led on the part of our hospitals to planning post-war additions or rebuilding. The service rendered by these hospitals under great difficulties and strain has been an essential contribution to the war effort, and much credit is due them. They have earned generous financial support of the citizens of our state in their building programs for the future. It is essential also that these hospitals have post-war building material priority as an emergency, if we are to quickly restore adequate hospital care for our citizens, including returning war veterans.

Hospital expense no doubt constitutes the greatest cost in medical care. It has here risen 37% in four years and probably will continue to rise due to prevailing high costs of living and of labor. Parenthetically, it is significant to make the comment that physicians' charges, determined through a questionnaire to doctors, revealed that of the nearly 200 returned, two-thirds of them have not increased their rates over 1940 despite increased living and operational costs to physicians.

#### *Blue Cross Expansion*

That the Blue Cross has shown such a remarkable growth in this state with a membership now nearly 40% of the state's population, is fortunate not only for the hospitals but for those members of the Blue Cross requiring hospitalization. In considering some of the possible causes for increased hospitalization this increased Blue Cross membership may have contributed; yet it is interesting to note that in the year 1944, 7.82% of the population of the state was hospitalized in some part of that year, yet of the Blue Cross membership only 7.23% were hospitalized. On the other hand, we must take into account that the Blue Cross membership must constitute a better risk group in comparison with the 60% not covered by Blue Cross.

There are other reasons for increased hospitalization. This rise in hospital admissions began long before we entered the war and during a period when Blue Cross was just getting started. Most influential in the increased hospital patient day load of over 25% would seem to be the inability of those ill at home to obtain such facilities as domestic help and any kind of nursing care. Again, homes are crowded and apartment living greatly increased. Furthermore, there is the factor of newer or special forms of treatment more safely given in hospitals. There is no doubt, however, that this grouping of patients in hospitals has made the doctor's load easier. Still another reason for greater hospitalization is the increase in workmen's

compensation cases admitted; accidents in industry have doubled in the war years.

#### *Industrial Health Problems*

Industrial employment in Rhode Island over recent years has shown, as would be expected, a marked increase. It is interesting to note that the peak was in 1942 and that there has been considerable falling off in war plant employment since then. Few people realize that this state is said to be the most industrialized state in the Union, and Providence County one of the most compact industrialized areas in the world. At times more than half of its population was employed in industry.

Growth in the realization of the importance of industrial hygiene and adequate medical facilities in the interests of workers and in economy of time is diverting many of our physicians and nurses into this field of work. In the future this will increase. Emphasis has been placed upon it not only in our Medical Society through its active committee on industrial health but through the State Department of Industrial Hygiene, as well as by many leaders in labor organizations and in industry.

Accidents and mortality in industry are far too many, and loss of work hours due to accidents and illness is a great handicap in our industrial war effort as well as an economic loss. (Chart 4). Most work hour losses were attributed to our still unconquered enemy, the common cold, with its sequelae.

Chart 4  
MORBIDITY AND MORTALITY DUE TO  
ACCIDENTS IN INDUSTRY IN  
RHODE ISLAND

	Accidents with Time Loss	Mortality
1940 .....	4711	13
1941 .....	7439	17
1942 .....	9497	24
1943 .....	9429	15
1944 .....	9474	18

Source — R. I. Dept. Labor

#### *Distribution of Graduate Nurses*

Hospitals, physicians and patients often wonder what has happened to all of our graduate nurses. Chart 5 approximately accounts for most of them. It is essential that we supply nurses for our military services. The military wounded deserve first call. It is also necessary that we disturb as little as possible, nurses in public health work. (There has been nearly a 25% reduction among visiting district nurses in our state; schools have been but little affected). Industry, however, as you know, has absorbed many of our graduate nurses.



Chart 5  
CLASSIFICATION OF GRADUATE NURSES  
IN R. I. (APPROX.)  
1944-1945

Active	Inactive	In Armed Forces	Public Health Nurses				
			Dep'ts Health	Dep'ts Educ.	Visit. Nurse Assoc's	Social Welfare	Industry
1946	688	463	51	38	111	3	119

(SOURCE—P&A COM.)      SOURCE—STATE DEPT HEALTH

### Voluntary Insurance Plans

You are all familiar with the studies, report and recommendations made by the technical committee of the State Voluntary Council on Health relative to prepaid hospital insurance coverage for workers. The Council on Health accepted and passed unanimously the technical committee's report and suggestion that for the present, instead of utilizing compulsory methods, greater effort be made to extend voluntary enrollment of workers in the Blue Cross organization, there being no other insurance competitors able to compete with rates comparable to those offered by Blue Cross. In this decision of the council the Governor concurred.

The matter of prepaid non profit voluntary surgical insurance coverage under the sponsorship of the Rhode Island Medical Society was referred to this society for further study. Such coverage was accepted in principle by our House of Delegates, and the matter is now in the hands of a committee composed of eleven men — six representatives of the Medical Society and five laymen — for study and development of a plan to be presented to the House of Delegates of our society for its action. The last session of the legislature passed an enabling act that the Medical Society may operate such a plan.

The reactions of nearly 200 of our physicians to these insurance problems has been determined through questionnaires. As a forward looking measure seeking additional ways in which diagnosis and medical care might be improved in our state, the attitude of our physicians was sought in reference to —

- 1) The development of hospital diagnostic centers in our state.
- 2) The introduction of some form of group practice.
- 3) The establishment of an industrial clinic for study and diagnosis of questionable or prob-

lem cases of disorders or diseases of industrial origin referred by our physicians active in industrial work.

These newer forms of approach to some of our problems, more popular in western states, showed surprising support among the 200 physicians answering the questionnaires.

### Disease Problems to be Attacked

Comparing the eight leading causes of death in Rhode Island in 1944 with 1920, expressed in cases per 100,000 population, we see at a glance where emphasis in our future attack on disease problems must be placed. Increased deaths from heart disease (it would seem reasonable to believe) are chiefly based on early degenerative processes associated with greater nerve tension and strain (Chart 6). They show an alarming increase in rate. Cancer is another problem which merits all the ways and means we can muster to check its ravages. It must be discovered early. Increased interest in this problem by our doctors and hospitals and other organizations is encouraging. It is surprising to note that deaths registered as diabetic show a 50% increase over 1920 in spite of the use of insulin. It only means that our diabetic patients must receive better study and care. It is very possible that increasing longevity and arterial changes are reflected in this rise in the death rate over 1920.

### Medical Education Plans

During the past year our society's committee on "Hospital, University and Medical Society Relations" has devoted a great deal of time to educational planning and other matters aimed toward improving medical care. A questionnaire sent out by this committee to doctors in military service brought 96 replies. Seventy (70) of these 96 doctors or 27% of all those in military service have already expressed themselves as desiring further hospital training or courses in specialties. In view of these requests it is encouraging that ten of our hospitals desire to offer to these men further opportunity for hospital experience through internships or residencies.

Among our civilian physicians 118 out of nearly 200 returning questionnaires which included inquiries on educational interests or desires, expressed themselves as interested in one or more types of medical education. If we practicing physicians are to keep pace with the astonishing and rapid advances in the science of medicine that we may give our citizens of this state the best in medical care, we shall need according to our varied special interests all the educational advantages that can be made available. The opportunities offered by Brown University through her newly formed Department of Medical Sciences, and the sympathetic attitude of Rhode Island State Col-

*continued on next page*

lege and Providence College in the matter of educational assistance are sure to improve medical care and teaching in our hospitals, stimulate research, and attract those desiring residencies and even fellowships.

This same committee has stimulated interest in the idea of a Rhode Island Institute of Pathology, somewhat familiar to most of you. It is to be hoped that there will be found a way to establish such an institution for the benefit of all of our hospitals. Strong departments in pathology are fundamental and one of the great needs in hospitals. They are essential to good diagnostic methods and medical care. The prohibitive costs of a well equipped and expertly manned laboratory deprive most smaller hospitals of this approach to greater efficiency. Part of the training of pathologists would be the covering of member hospitals for special work. Training of technicians for these member hospitals with continued supervision would fill a great need. Teaching and research work would be stimulated and put on a much better foundation. The interest aroused at the present time in this project is a manifestation of the need of better pathology. Most hospitals and doctors are in favor in principle of such a development.

The associating of hospitals in the interest of better pathology in our state through an Institute of Pathology, should it become a successful reality, has a much deeper significance in that it will have launched that most desirable approach to what now seems an excellent solution of the problems of better distribution of medical care; namely, taking the first step in a cooperative set-up, integrating

hospitals, pooling of facilities for better diagnosis and treatment. Such a venture will carry along with it additional educational advantages. This system would encourage community medical centers and not only increase the number of but the quality of service given by general practitioners, and furthermore stimulate specialists to practice in such communities.

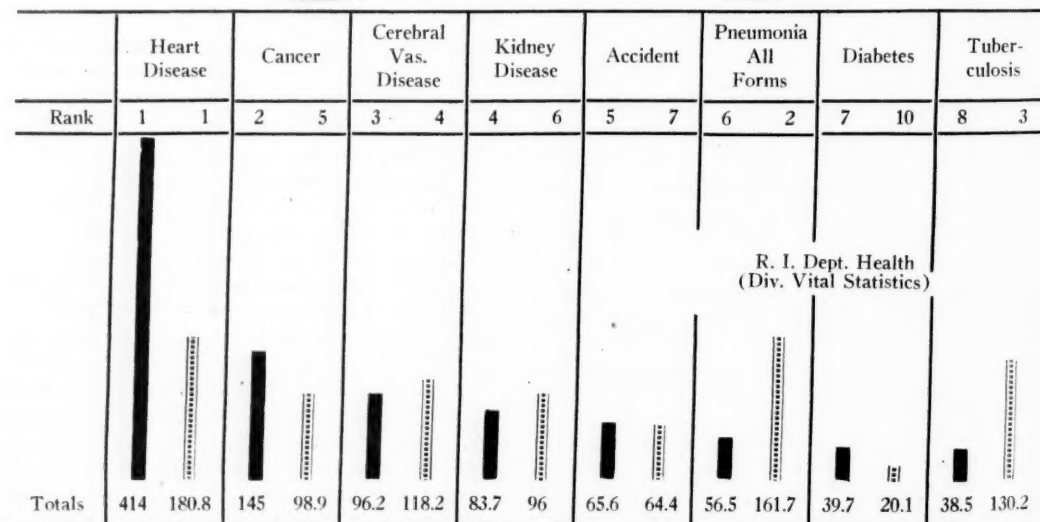
The companion problem to better distribution of medical care is the lowering of the cost of medical care. Some of the time honored customs of lowering costs are the cooperative method, the sharing method, the pooling of expenses, etc. Therefore, in trying to solve the distribution of medical care by associative methods are we not approaching the solution of lower costs in medical care?

It would seem imperative then that we not let this opening wedge of interest slip, lest we fall back and soon allow to enter some form of Federalized control. Our hospitals and our physicians should do all in their power to encourage better quality and better distribution of medical care and at lowered costs. We know an implement to use toward this end. This project of a Rhode Island Institute of Pathology needs your immediate and enthusiastic support.

#### Problems Requiring Study

There are many other pressing problems needing our study and action now. Very important among these is further planning for the care of our returning veterans. Cooperation with state planning has been going on over the past few months.

Chart 6  
RANK AND DEATH RATES PER 100,000 POPULATION IN R. I.  
1944 COMPARED WITH 1920





Also our society is cooperating in our state plan for the rehabilitation of workers. In the months and years to come, we physicians here in Rhode Island must assume our full share of responsibility in private practice and in hospitals in giving these men the best that our facilities will afford.

Our Society is taking the lead in encouraging other New England State Medical Societies in a revived interest in the formerly established but inactive New England Medical Council. There are many functions which such a council could have. One is in encouraging greater uniformity in the establishing of many policies; for example, that of fee schedules for physicians doing various types of departmental work.

Further needs in our state in the interests of better medical care are more and better hospital facilities for the care of the chronic sick; also institutions specially devoted to convalescent care of patients leaving hospitals for acute illness and requiring further rest. This would, by shortening patient days in the hospitals, open the way for admitting many on our hospital waiting lists, and likewise reduce costs of hospital care, especially to the patient.

Another need is the finding of a way of securing the legislation in public health and other medical matters which is in the best interests of the people. Many of these problems are of sufficient importance to the public to be carried to them. The people have a fine representative body in the Voluntary State Council on Health. Would not this Governor's appointed council of 35 respected leaders from various organizations in our state be an excellent reviewing body for such studies?

Finally, we as physicians must enter more into public relations. People must know more about real values in medical care under the system of free enterprise in contrast to dangers involved in government controlled socialized medicine. We as physicians must know better the problems of the people, of industry, and of labor, and all representative groups. Much misunderstanding, lack of knowledge, and criticism can be cleared away and real progress made through cooperation. The people are the recipients of medical care and have rights in medical care which should be respected. They, on the other hand, know far too little about what our profession has done and is doing and will do for them if we understand each other and will cooperate in the interests of better health and better medical care.

## SOME RECENT ADVANCES IN THE CONTROL OF INFECTIOUS DISEASES

*continued from page 415*

- <sup>26</sup>Stanley, W. M. The preparation and properties of influenza virus vaccines concentrated and purified by differential centrifugation. *J. Exper. Med.* 81: 193, 1945.
- <sup>27</sup>Mueller, J. H. Annual Report for 1943-44 of the Commission on Epidemiological Survey, Army Epidemiological Board, Preventive Medicine Service, Office of The Surgeon General, U. S. Army. Unpublished.
- <sup>28</sup>Schoenbach, E. B. The meningococcal carrier state. *M. Ann. District of Columbia* 12: 417, 1943.
- <sup>29</sup>Phair, J. J., and Schoenbach, E. B. The dynamics of meningococcal infections and the effect of chemotherapy. *Am. J. Hyg.* 40: 318, 1944.
- <sup>30</sup>Kuhns, D. M., Nelson, C. T., Feldman, H. A., and Kuhn, L. R. The prophylactic value of sulfadiazine in the control of meningococcal meningitis. *J. A. M. A.* 123: 335, 1943.
- <sup>31</sup>Phair, J. J. Annual report for 1943-44 of the Commission on Meningococcal Meningitis, Army Epidemiological Board, Preventive Medicine Service, Office of The Surgeon General, U. S. Army. Unpublished.
- <sup>32</sup>Bureau of Medicine and Surgery, Navy Department. The prevention of respiratory tract bacterial infections by sulfadiazine prophylaxis in the United States Navy. *Navmed.* 284, 1944.
- <sup>33</sup>Simmons, J. S. The prevention of malaria in the U. S. Army. *Trans. Assoc. Am. Phys.* 58: 62, 1944.
- <sup>34</sup>Cruickshank, R. Hospital infection: a historical review. *Brit. Med. Bull.* 2: 272, 1944.
- <sup>35</sup>Robertson, O. H., Bigg, E., Miller, B. F., and Baker, Z. Sterilization of air by certain glycols employed as aerosols. *Science* 93: 213, 1941.
- <sup>36</sup>Robertson, O. H. Sterilization of air with glycol vapors. *The Harvey Lectures* 38: 227, 1942-1943.
- <sup>37</sup>Robertson, O. H. Annual report for 1944-45 of the Commission on Air-Borne Infections, Army Epidemiological Board, Preventive Medicine Service, Office of The Surgeon General, U. S. Army. Unpublished.
- <sup>38</sup>Miles, A. A. Observations on the control of hospital infection. *Brit. Med. Bull.* 2: 276, 1944.
- <sup>39</sup>Van den Ende, M., Lush, D., and Edward, D. D. Reduction of dust-borne bacteria by treating floors. *Lancet* 2: 123, 1940.
- <sup>40</sup>Thomas, J. C., and Van den Ende, M. The reduction of dust-borne bacteria in the air of hospital wards by liquid paraffin treatment of bedclothes. *Brit. M. J.* 1: 953, 1941.
- <sup>41</sup>Robertson, O. H., Puck, T. T., Loosli, C. G., Hamburger, M., Jr., Lemon, H. M., and Wise, H. A new approach to the control of air-borne infection. *Trans. Assoc. Am. Phys.* 58: 171, 1944.
- <sup>42</sup>Mahoney, J. F., Arnold, R. C., and Harris, A. Penicillin treatment of early syphilis: a preliminary report. *Ven. Dis. Inform.* 24: 355, 1943.
- <sup>43</sup>Moore, J. E., Mahoney, J. F., Schwartz, W., Sternberg, T., and Wood, W. B. The treatment of early syphilis with penicillin. A preliminary report of 1,418 cases. *J. A. M. A.* 126: 67, 1944.
- <sup>44</sup>Editorial: War and Insecticides. *J. A. M. A.* 128: 30, 1945.

*Buy War Bonds  
and Stamps*

# The RHODE ISLAND MEDICAL JOURNAL

*Owned and Published Monthly by the Rhode Island Medical Society,  
106 Francis Street, Providence, Rhode Island*

## EDITORIAL BOARD

PETER PINEO CHASE, M.D., *Editor-in-Chief*, 122 Waterman Street, Providence

JOHN E. FARRELL, *Managing Editor*, 106 Francis Street, Providence

CHARLES J. ASHWORTH, M.D.

CHARLES BRADLEY, M.D.

ALEX M. BURGESS, M.D.

JOHN E. DONLEY, M.D.

H. LORENZO EMIDY, M.D.

CHARLES L. FARRELL, M.D.

ISAAC GERBER, M.D.

PETER F. HARRINGTON, M.D.

HERBERT G. PARTRIDGE, M.D.

HENRY E. UTTER, M.D.

GEORGE L. YOUNG, M.D.

## COMMITTEE ON PUBLICATION

HAROLD G. CALDER, M.D., *Chairman*, Providence

PAUL APPLETON, M.D., Providence

WILLIAM P. BUFFUM, M.D., Providence

AUGUSTINE W. EDDY, M.D., Woonsocket

JOHN F. KENNEY, M.D., Providence

## THE NEW WAGNER ACT

Within the past month the new Wagner act broadening the social-security program, strengthening the employment service, and extending health services and facilities was introduced in Congress, and as S. 1060 it has been committed to the Committee on Finance for study. So much was written about the similar legislation presented to Congress two years ago by Senators Wagner and Murray, and Congressman Dingell, we may well anticipate a flood of pros and cons about the current measure.

A summary of some of the major provisions of the new act is presented on page 427 of this issue of the JOURNAL. This summary is by the sponsors of the bill, and we have not as yet had the opportunity to study the measure in its legislative form and to interpret thereby just how complete are the provisions of the act, and how wide its implications. The medical profession of Rhode Island, as well as the remainder of the country, will, we are sure, support any attempt to improve the health and welfare of the people provided the procedures by which that improvement is to be made possible are sound and within the social patterns that are well understood by the people.

Our concern will be that the attempts at such improvements in social progress do not introduce equal or greater hazards and dangers than those

which we seek to overcome. Will the grants and loans to the States for the construction of needed hospitals be made without restrictions that will tie the future successful operation of such institutions to the dictates of a changing political structure? Will such hospitals escape the fate which now has apparently overtaken veterans' hospitals, and which has marked the existence of so many state-dominated institutions?

In the expansion of the public health services will the private physician be a participant to the extent he should be, or will he be submerged under the dominance of federal operatives who, by administrative law if not otherwise, set policies of far reaching significance to the medical and health care of every citizen with little or no regard for the physician who is to render the services?

Will such legislation really provide freedom of medical practice as the American doctor, and his patient, understand the term? Will it really guarantee as good medical care for everyone as now exists, or does it merely promise better care on the assumption that tax funds will provide the finances to purchase more services than actually exist or are necessary in every instance? Will it guarantee this aid without making the beneficiary politically dependent?

These and countless other questions can and will

be asked. The answers must be forthcoming. We are clear in our purpose in that we seek improvement, but we must be sure that the improvement will actually be attainable, and that it will be permanent. To accept anything less would be a compromise that we cannot tolerate. Not alone the medical profession, but all citizens must be educated to a clear understanding of all the features of this legislation—and that education must be without bias or prejudice; on the contrary, predicated on firm judgments backed by logical reasoning and sound actuarial studies.

For example, the new Wagner act proposes a temporary disability benefit of \$30 weekly for the married worker with two or more children, provided his weekly wage is \$40 or more, for a period of 26 weeks and possibly 52 weeks as the plan develops. Yet here in Rhode Island where we tax the employee alone for temporary disability as much as would be collected from both the employer and employee under the Wagner measure, we are facing a terrific financial loss in our Cash Sickness Fund which pays but a maximum of \$18 weekly for a maximum of but 20 weeks. Such experience in this State where employment and wages are at the highest peak in history is sufficient reason for us to be concerned over the actuarial soundness of a national program encompassing all the population, and with a far lower per capita income than we claim.

As a profession the doctors of Rhode Island are not standing still in this question of the distribution of medical services. We strongly backed the Blue Cross. We originated and supported wholeheartedly the idea of a State Voluntary Advisory Council on Health. We are exploring the best plan for a permanent medical and surgical insurance program on a voluntary basis, and we have been foremost in the support of public health programs.

We will want to study the new Wagner act carefully and intelligently. We re-iterate the statement made in December, 1943, in conjunction with the other medical societies of New England that "we shall be glad to work out plans with representatives of the Federal and State governments to improve the health of all the people, but we should expect that any plans that might be devised would take full advantage of existing agencies and should be developed within the social patterns that are well understood by the people."

### DISCRIMINATION

In spite of the protests of the Rhode Island Medical Society the Governor signed a bill passed in the final days of the recent session of the General Assembly which stipulates that "no discrimination shall be made by any state department for or against any osteopathic physician or optometrist,

in any medical plan which involves the expenditure of state funds."

What does the act mean? The Assembly did not permit the Medical Society to have a hearing on the measure. The Governor was equally uncommunicative when asked by the Society to veto the measure because of its ambiguity. Webster, upon whom we all lean for the interpretation of words, defines discrimination as "*an act of discriminating*", i. e., "*marking or noting a difference or differences; distinguishing*". Another definition given for the word is that of "*a distinction, as in treatment; esp., an unfair or injurious distinction*". Just what phase of the definition is implied in the act now written into our laws without public explanation?

If there has been any unfair distinction in any state department involving medical plans, what is it? The medical profession has always maintained that a distinction, or call it discrimination if you will, should exist between those who are qualified and those who are not, in the rendering of various phases of medical care. It has long supported the regulations written into programs administered by the State or other agencies that only those medical men with the best medical educational background should be permitted to participate in programs involving the health of the public.

Osteopaths and optometrists are licensed to participate in limited fields of the healing art. Osteopathy is not medicine; nor is optometry. The approval of the discrimination act by the Governor is but another approval of the efforts of such groups to circumvent the statutes limiting their professional fields. That there is not discrimination of unfair distinction in such limitation was clearly set forth years ago by the Rhode Island Supreme Court in an historic case in which it cited that ". . . To protect the public, not from theories, but from the acts of incompetent persons, the legislature has prescribed the qualifications of those who may be entitled to perform the important duties of medical practitioners. The statute is not for the purpose of compelling persons suffering from disease to resort to remedies, but it is designed to secure to those desiring remedies competent physicians to prepare and administer them."

Medical plans can mean only one thing—medical care by doctors of medicine. Let's keep that straight, and if any allied services are eligible under any health programs let's call them by their right name, and stop blanketing them under the title of medical services.

### MEDICINE IN MICHIGAN

The public relations conference convened by the Michigan Medical Society at Detroit late in April, with the presidents of seventeen state medical

*continued on next page*

societies in attendance, marked a new high in a sensible approach to the problems facing American Medicine. For the first time, to our knowledge, the heads of representative state medical organizations had a chance to sit about the conference table and discuss the best approaches to solve the question of the better distribution of medical care in the United States.

As leaders in their respective states the physicians who traveled to the Detroit Conference were eminently qualified to express the viewpoint of the physicians of America. Their willingness to take time from other pressing duties to gather at the invitation of the Michigan State Society, and to discuss freely and vigorously the problems facing the doctor, was a tribute to the leadership which they have taken in their own areas.

Whether state drafting panels to inform better the American Medical Association of the states' wishes in regard to national health legislation, or whether a medical public relations program via radio for the seventeen states materialize as the result of the Conference is almost of secondary importance. The major significant feature of the meeting remains in the fact that for the first time the State Society presidents were assembled to give their report on the thinking at the state level. Michigan is certainly to be congratulated for its initiative and for its progressive leadership in medicine. We all have gained by the Detroit conference.

#### 1945 ANNUAL MEETING

The one hundred and thirty-fourth annual meeting of the Rhode Island Medical Society was held at the Medical Library in Providence May 16 and 17, 1945. The Society enjoyed the distinction this year of being one of the few in the country permitted by the Office of Defense Transportation to hold an annual meeting, and as a result the enthusiasm for and attendance at the sessions in Providence undoubtedly surpassed anything that has been observed locally in the past.

The attendance this year was unusually good. Three hundred and eighty-four members of the State Society registered as visitors at the sessions. There were eighty-nine other physicians in attendance, and one hundred and sixty-nine non-medical visitors, including exhibitors, were present. We were particularly glad to welcome visitors in the audience from Massachusetts and Connecticut where the state societies were unable to hold meetings this year. The number of exhibitors, totaling twenty-seven commercial firms, was far in excess of the number present at any past meeting.

All sessions of the meeting this year were held at the Rhode Island Medical Library with scientific presentations the afternoon and evening of May

16th and the morning and afternoon of the following day. In addition, the opening sessions were preceded by meetings in the same auditorium on May 16th by the Rhode Island Association of Medical Record Librarians and the Rhode Island Medical Social Workers Association. A number of members of these associations remained for the medical meeting.

There was an unusually large attendance at the opening scientific program on Wednesday afternoon, and all the papers presented were heard by an attentive and enthusiastic audience. Interspersed among the papers were intermissions during which those in attendance took advantage of the opportunity to visit the many technical exhibits, and the afternoon program was concluded by a social hour at the neighboring Biltmore Hotel for all members and guests. This social hour has become an annual fixture that appears to increase in popularity each year. Following the social hour officers of the Society and committee members entertained official convention guests at dinner at the Hotel and then proceeded to the evening program, where Dr. Francis G. Blake, Dean and Sterling Professor of Medicine, Yale University School of Medicine, New Haven, Connecticut, delivered the Charles V. Chapin Oration on "Some Recent Advances in the Control of Infectious Diseases."

Dr. Blake confined his report to the newer developments in this important field which have resulted from concentrated study by various national and military research projects during the last four years. The Society was honored by the presence at this meeting of His Excellency, J. Howard McGrath, Governor of the State of Rhode Island, and by Honorable Dennis J. Roberts, Mayor of the City of Providence and Dr. Roger I. Lee, president-elect of the American Medical Association. Governor McGrath addressed the Society briefly prior to Dr. Blake's presentation and at its conclusion Mayor Roberts presented the Charles V. Chapin Memorial Award in the form of a suitably inscribed medal to Dr. Blake.

The scientific presentations were continued all day Thursday, with a noon intermission featured by a luncheon for the members of the Society and their guests at the Library. The excellence of the papers, and the splendid presentation of each, result in a capacity audience throughout the entire day. The program was concluded by Dr. E. S. Wing whose Presidential address on the medical care in Rhode Island was both timely and significant.

With the installation of officers for 1945-46, the 134th annual meeting was officially ended with a rising vote of tribute to Dr. Jesse E. Mowry, who had served the Society faithfully and well as its Treasurer for more than twenty years.



## REPORT OF A CASE OF EMPYEMA TREATED WITH PENICILLIN

LOUIS I. KRAMER, M.D.

The Author. Louis I. Kramer, M.D. of Providence, Physician-in-chief, C. V. Chapin and Miriam hospitals; Acting Visiting Physician, Rhode Island hospital.

CURES of empyema with penicillin have been reported in the literature, but so far the number hasn't been too voluminous to feel that another report would be superfluous. E. C. B. Butler and associates<sup>1</sup> reported seventeen cases, ten of which were due to streptococcal infection and seven to pneumococcal organism. Of these cases reported thirteen got well, two improved greatly and two died. William S. Tillet and associates<sup>2</sup> reported eight cases of pneumococcal empyema treated with penicillin, of which six completely recovered with local therapy and without surgical interference while one case developed a bronchopleural fistula which persisted; one case came to surgery because of insufficient treatment with penicillin in the beginning. Chester S. Keefer, et al,<sup>3</sup> reported nine patients treated with penicillin with seven recoveries. T. I. Bennett, et al,<sup>4</sup> reported three cases, two of which were due to streptococcal infection and one to staphylococcus infection with complete recovery in all three cases.

*Case report*—B. K., a 68 year old sheet metal worker, was admitted to the hospital April 3rd, 1944, complaining of hematuria. Four days prior to hospital admission, and for the first time, upon urinating he passed bright red blood. There was no pain. Previous to this episode he had been suffering from frequency and nocturia of a progressive nature for the past two years. Past history was non-contributory except for the usual diseases of childhood and the discovery of a duodenal ulcer in 1937. On March 8th, 1944, he met with an accident, at which time he fractured his sixth and seventh ribs on the right side. He complained of occasional cough but there was no dyspnea, ankle edema or hemoptysis.

Admission temperature was 98 degrees, pulse rate was 100, and respirations were 20 per minute. Eyes: Pupils were normal, round, equal, regular and reacted to light. Ears: Grossly negative. Nose: Grossly negative. Throat: Slightly injected. Teeth: Edentulous. Neck: No rigidity nor palpable lymph glands. Chest: Barrel shaped. Antero-posterior

greater than lateral diameter. Lungs: Hyper-resonant. Breath sounds distant. No basal rales. Lungs were emphysematous. Heart: Rate 100, rhythm regular, sounds inaudible. There was slight enlargement to the right. Blood pressure was 116/70. Abdomen: Scaphoid, no scars, no pain nor tenderness. There were no palpable masses nor solid organs felt. Reflexes were physiological. Skin: Tape over the left chest under which were several red lines and crusts. Rectal: Examination revealed a prostate which was smooth, firm and hypertrophied.

X-ray of the chest April 4th, 1944: Examination of the chest showed a diffuse area of increased density in the left lower lobe typical of pneumonitis. Other portions of the lungs were clear and showed no pathology. The diaphragm had a normal contour and there was no evidence of free fluid in the pleural cavities. Preliminary film of the abdomen showed an opaque dense shadow in the left upper quadrant which measured about two centimeters in length and one centimeter in diameter and appeared to be outside the genito-urinary tract, but its exact significance could not be determined without further study. The kidneys were normal in size, position and outline and there were no opaque calculi in the genito-urinary tract, but its exact significance could not be determined without further study. The kidneys were normal in size, position and outline and there were no opaque calculi in the genito-urinary tract. The lumbar spine and pelvis showed moderate hypertrophic changes, but there was no metastatic bone involvement.

On the 6th of April, 1944, a suprapubic cystotomy and bilateral partial vasectomy was done. The patient's post-operative course was satisfactory and his temperature remained normal except for an occasional spike to 99.6 degrees. On the 18th of April a second stage suprapubic prostatectomy was performed. Temperature remained normal for three days following operation, but the pulse rate rose to 130 for two days, after which it stayed at around 90. On the 21st of April, three days post-operative, his temperature rose to 100 degrees, pulse rate to 108 and respirations to 25. On the sixth post-operative day his temperature was 101.6 degrees, pulse was 120 and respirations 30. At this time he developed a cough which was non-productive. There was nothing surgically to

*continued on next page*

account for the persistent temperature. On the 30th of April, 12 days post-operative, I was called in on consultation. Examination of the left chest revealed dullness to percussion from the angle of the scapula downward to the base and laterally to the axilla, breath sounds were absent at the extreme base. Vocal and tactile fremitus were not present. The findings were consistent with the presence of fluid. The right chest was entirely negative. The patient had been on sulfadiazine, 1 gram every 4 hours, daily since the 21st of April. This dose was increased to 2 grams every 4 hours. The white blood count on the 30th of April was 18,700 with a differential of 82 polymorphonuclears, 17 lymphocytes and 1 monocyte. On the 30th of April another chest X-ray revealed the following:—Examination of the chest showed increased density throughout the entire left side which may have represented a diffuse consolidation in the lung but there was obliteration of the left border of the heart, diaphragm and lower lung field, consistent with some fluid in the pleural cavity. The right lung showed no pathology and the right diaphragm was of normal outline. There was a fracture of the 6th right rib in the axillary line probably due to an old injury.

On the 3rd day of May, a paracentesis yielded but 5 cubic centimeters of cloudy fluid mixed with blood. A smear of the chest fluid showed many red blood cells, a few white cells, but no pus cells nor organisms. A culture report revealed gram positive cocci in chains. In spite of a sulfadiazine blood level of 10.3 mgs. per cent, the patient showed no improvement whatsoever. Re-examination of the chest by X-ray, May 7, 1944, showed slight clearing of the density throughout the left lung. There was a sharply delineated dense shadow along the upper outer portion of the chest, which was consistent with encapsulated fluid. The right lung remained clear. A chest tap was repeated on the 13th of May and yielded thick stringy greenish-gray pus which showed many gram positive cocci in chains and on culture green nonhemolytic streptococci.

On the 18th of May another chest tap was done. About 20 cubic centimeters of grayish-green pus was withdrawn and 50,000 units of penicillin in 10 cubic centimeters of distilled water was injected into the empyema cavity. Aspirations followed by instillations of 50,000 units of penicillin were continued daily for eight consecutive days. During this time the pus withdrawn from the cavity became much thinner and less stringy.

X-ray interpretation May 22nd, 1944: Repeat antero-posterior and lateral views of the chest showed a large empyema cavity in the upper posterior portion of the left side, with a fluid level at the 5th posterior interspace. There was increased

density in the lower half of the chest obliterating the diaphragm shadow, which in the lateral view appeared as a sharply delineated shadow in the posterior portion of the chest, consistent with another larger loculation of fluid. The right lung remained clear. The right diaphragm was in good position and of normal outline.

After eight consecutive days of penicillin therapy, four days were allowed to lapse before giving the drug again, and then it was given every third or fourth day for three doses of 50,000 units each except on one occasion when 75,000 units were instilled. Temperature dropped to normal May 23rd, 5 days after penicillin treatment was instituted, and remained normal thereafter. Clinically, the patient improved soon after penicillin was started. Culture of the chest cavity fluid became sterile on the eighth day of treatment.

Re-examination of the chest by X-ray, May 31, 1944, showed considerable diminution in the amount of fluid in the empyema cavity in the upper portion of the left side of the chest, but there was a large loculation of fluid in the posterior half of the left side of the chest, with a fluid level opposite the 8th posterior rib. The right lung remained clear. Although the fluid still remained in the pleural cavity, clinically the patient was well and was discharged on the 4th of June.

He has been followed for five months, during which time three chest X-rays have been taken, the last of which was reported as follows:—

August 7th, 1944: Direct comparison with the previous films showed considerable improvement and the density in the lower left side of the chest was almost completely cleared. There was no evidence of free or loculated fluid in the pleural cavities. The right lung remained clear and the heart and great vessels were within limits.

#### Summary

A case of empyema following pneumonitis treated with daily instillations of penicillin into the empyema cavity with complete recovery.

#### Comment

The treatment of empyema by the closed method is not new. During the first world war many cases were treated by aspiration and instillation of Dakin's solution with excellent results in a high percentage of cases. But at no time did this type of treatment replace surgery, nor is the case presented intended to convey the idea that penicillin will take the place of surgery. A large percentage of cases, particularly those that develop a broncho-pleural fistula will have to be treated surgically. However, in view of the good results obtained in a number of cases treated with penicillin and the ease with which this can be accomplished, this type of therapy deserves consideration and fair trial.

*continued on page 445*



## SUMMARY OF THE MAJOR PROVISIONS of the SOCIAL SECURITY AMENDMENTS OF 1945

(Proposed by the Wagner-Murray-Dingell Acts Introduced in Congress, May 24, 1945)

*Prepared by the Executive Office of the Rhode Island Medical Society from remarks made regarding the Act by Senator Wagner as reported in the CONGRESSIONAL RECORD, May 24, 1945.*

### UNITED STATES SENATE

Washington, D. C.

May 31, 1945

Peter P. Chase, M.D., Editor  
Rhode Island Medical Journal  
106 Francis Street  
Providence, Rhode Island

Dear Dr. Chase:

On Thursday, May 24, I introduced with Senator Murray a bill, S. 1050, entitled: "The Social Security Amendments of 1945." The bill provides for "the national security, health and public welfare." Representative Dingell of Michigan introduced a companion bill (H. R. 3293) in the House at the same time.

I am forwarding the bill itself, and a copy of my speech in the Senate for your information and use.

I particularly invite your earnest study of the provisions of the bill relating to health. There is absolutely no intention on the part of the authors to "socialize" medicine, nor does the bill do so. We are opposed to socialized medicine or to State medicine. The health insurance provisions of the bill are intended to provide a method of paying medical costs in advance and in small convenient amounts.

During the formulation of this bill we have benefited greatly from the constructive advice and suggestions of practicing physicians, and of physicians in clinical and teaching positions. Their constructive suggestions have resulted in changes in the bill which we presented in the last Congress. Undoubtedly other changes will be made before this bill is enacted into law. We wish to have it known that we invite constructive suggestions from the medical profession.

In addition, members of the medical profession will be given full opportunity to voice their opinions in open hearings when the bill is considered in Committee.

I hope that you will print this letter in your Journal and that you will join me in urging the medical profession to undertake an earnest study of the actual provisions of the bill. In this way you can help immeasurably in avoiding misunderstanding and misinterpretation of the legislation and in stimulating physicians and medical and hospital organizations to come forward with constructive suggestions and advice.

Sincerely yours,

(signed) ROBERT F. WAGNER

### SECTION 2. Grants and Loans for Hospital and Health Center Construction

Section 2: This section provides for a 10-year program to build, improve, and enlarge hospitals and health centers as needed, especially in rural communities and areas where facilities are overtaxed as a consequence of the war and where the need for additional facilities is likely to continue. In order that the facilities shall be built most advantageously where they are needed, surveys are to be made by the States. A total of \$5,000,000 is authorized to be appropriated, to provide grants to the States to assist them (with their own funds) to make the surveys. The Surgeon General of the Public Health Service is authorized to make such surveys in the event a State does not do so.

A total of \$950,000,000 is authorized to be appropriated over a 10-year period for construction grants and loans, of which \$50,000,000 is for the fiscal year 1946 and \$100,000,000 for each of the 9 succeeding years. The program is to be administered by the Surgeon General of the Public Health Service, with the assistance of the Federal Works Agency, on construction matters.

Grants, or grants and loans, may be made to States, their political subdivisions and to nonprofit organizations for hospitals and health centers. All amounts appropriated are to be available until spent, except that balances at the end of the tenth year, and loans as they are repaid, revert to the Treasury. Loans are to be repaid within 20 years and are limited to hospitals which receive grants. The grants shall be for not less than 25 percent nor more than 50 percent of the cost of the project, exclusive of the cost of the site. Loans may not exceed 25 percent of the cost of the project.

Grants for construction projects are adjusted according to a formula specified in the bill and based upon the per capita income of each State compared to the average for the United States. The same formula applies to grants toward the cost of administering the State construction plans.

Applications for grants and loans are to be made to the Surgeon General and shall include the information necessary to establish the need for the hospital project, to show that the project is in accordance with the State construction program and is approved by the State agency, to show that the applicant needs a grant or a grant and loan, and that the hospital will be used so as to furnish services of satisfactory quality in accordance with standards prescribed by the State.

In the event a State has not developed a construction program by January 1, 1948 the Surgeon General may make State surveys of needed facilities, and may approve applications that are in accord with the results of such surveys. Prior to that date he may not approve an appli-

*continued on next page*

cation for projects in States that have no approved plan unless the application is for an urgently needed facility in a rural, semi-rural, or a war-distressed area, for an existing hospital that cannot continue to operate without the new project, or for a health center approved by the State Health agency.

A National Advisory Hospital Construction Council is established to advise the Surgeon General in the administration of this program particularly with respect to standards for determining the need for additional hospital facilities, for assuring proper construction and equipment, and adequate maintenance and use. The Council is to have nine members — the Surgeon General ex-officio, and eight members appointed by him after consultation with the National Advisory Medical Policy Council and with the approval of the Federal Security Administrator. The eight appointed members shall be selected from leading medical and other authorities and from among persons who are concerned with the need for hospitals in urban and rural areas. The Council is to review and to make a recommendation upon each application for grants. Specific provision is made to assure that hospitals assisted under this program will remain free from control by the Federal Government.

#### SECTION 4. *Increased Grants to States for Public Health Services*

This section amends section 314 of the Public Health Service Act. The subsections concerned with grants for the venereal disease and for the tuberculosis programs are unchanged. The subsections dealing with general public health work are revised so as to strengthen the program and pledge complete Federal cooperation to the States in moving as rapidly as practicable toward the development of adequate public health services in all parts of the country. The present authorization of \$20,000,000 a year for grants to States is replaced by an authorization to appropriate a sum sufficient to carry out the purposes. Also, the annual amount available to the Surgeon General of the Public Health Service for demonstrations, training of personnel, and administrative expenses is increased from \$3,000,000 to \$5,000,000 a year.

In order to receive the Federal grants the States are required to develop their own plans in accordance with their own needs, and to submit these plans for approval. They must be approved by the Surgeon General if they meet the requirements that are specified. An orderly system of arrangements is laid down, ensuring reasonable standards and systematic financial participation by the States (and by the localities cooperating under the State plans). This is the same general pattern as has been followed for public assistance since the original Social Security Act of 1935. The amounts of the grants to States are determined by an explicit formula, designed to give relatively more aid to the poorer States and relatively less to the richer States. The variable Federal grants would range from 25 to 75 percent of the total public funds expended under the approved State programs.

#### SECTION 5. *Increased Grants to States for Maternal and Child Health and Welfare Services.*

This section amends title V of the Social Security Act relating to Federal cooperation with the States to provide health and welfare services for mothers and children. A common plan is followed in each of the three parts, dealing respectively with maternal and child health, crippled children, and child welfare. In order to receive Federal grants, the States are to develop their own plans, in accordance with their own needs. If these plans meet the requirements specified, they must be approved by the Chief of the Children's Bureau. The requirements are those

that are essential to insure reasonable standards, systematic financing and administration, and reasonably rapid extension of the services to all parts of the States and on an adequate basis. Administration by the Federal authorities shall be in close consultation with the State authorities. As in the case of grants for public-health work and public assistance, the Federal grants would be on a variable basis, so as to give special aid to the poorer States. The variable Federal grants would range from 25 to 75 percent of the total public funds expended under the approved State programs, the amount in each case being determined by a specific formula written into the law. The Federal Government would be entering into full partnership with the States in providing services for mothers and children, leaving wide latitude to the States as to the scope and content of the programs.

#### SECTION 6. *Comprehensive Public-Assistance Program*

This section provides Federal grants to States for assistance to all needy persons. It provides variable Federal grants to the States ranging from 50 percent to 75 percent of the total expended, depending upon the State's per capita income. The higher rates apply to the States with the lower per capita incomes. The program authorizes Federal matching, on this variable grant basis, of money payments to any aged person, dependent child, blind person, or other needy individual (without the rigid maxima provided by existing law); and where so provided in an approved State plan, medical services to needy individuals, payments for the care of children in foster homes, and such services as may assist in making needy individuals self-supporting.

These Federal grants, like the similar provisions of the present law, are made out of general revenues. As under existing law, State plans must meet various requirements, including maintenance of civil-service merit standards for administrative personnel. In determining need, the State must take into consideration any other income of any individual claiming assistance except that the State may, in its discretion, not take into consideration any amounts of current income received by an individual up to \$20 per month, as the state may determine. . . .

In the interests of economy and efficiency of operation the bill provides that there be one State agency and also only one local agency to administer all assistance in each locality.

The bill also provides that special consideration should be given to the special needs of individuals. The bill specifically provides that where an individual has special needs because of illness, disability, or special costs due to employment, education, or the like such persons shall have these factors taken into account in the determination of the individual's need.

#### SECTIONS 7 AND 8. *A National System of Employment Offices*

Section 7. This section provides for an expanded and strengthened national system of public-employment offices established in the Social Security Board to assist war workers, war veterans, and all others to avail themselves of civilian employment opportunities throughout the Nation, to promote employment in private industry and on farms, and generally, to bring together available workers and available jobs in the maximum use of the Nation's productive facilities and manpower. Among other duties, the expanded Employment Service is directed to provide facilities in cooperation with the administration of unemployment insurance. . . .

Sec. 8. This section provides for the repeal of the Wagner-Peyser Act under which the Federal-State Employment was originally established.

SECTION 9. *National Social Insurance System.**Part A. Prepaid Medical Care Insurance*

Part A of this section provides for medical and hospital insurance.

Freedom of medical practice is carefully safeguarded. Each insured person is entitled to choose his own doctor from among all physicians or groups of physicians in the community who have voluntarily agreed to go into the insurance system. Each doctor or group of doctors is free to go in or stay out of the insurance system. These doctors who participate are free to accept or reject patients who may wish to select them as their family doctor, and the participating doctors are likewise free to choose the method through which they are to be paid from the insurance fund. Patients and doctors may change the arrangements after they have been made if they become dissatisfied. Doctors practicing as specialists, individually or in groups would be entitled to special rates of payment if they meet professional standards for specialists. Thus, existing arrangements for choosing a doctor and obtaining medical, laboratory, or hospital care would not be disturbed.

The bill contains various provisions to assure that medical benefits will be the highest quality that can be made generally available, will promote personal relations between doctor and patient, will emphasize prevention of disease, and will be adapted to the needs and practices of the community, in both rural and urban areas.

The Surgeon General of the United States Public Health Service—a doctor—would administer the technical and professional aspects of the program. The Surgeon General would also be authorized to work out the closest possible coordination between the medical, and hospital services and the public health services of the Federal, State, and local governments.

Hospital care is limited to 60 days per year, with a possible maximum of 120 days if experience proves that the insurance fund can afford it. All qualified hospitals are eligible to participate. The Surgeon General is forbidden from exercising supervision or control over the management of hospitals that participate in the insurance system.

The Surgeon General is directed to establish a national advisory policy council. Members of this advisory council would be appointed from panels of names submitted by professional and other organizations concerned with medical services, education, hospitals, etc. The advisory council must also include representatives of the public.

Specific provision is included for hearings and appeals on any disputed issues between practitioners, hospitals, and insured persons. Specific provision is made for the judicial review of any disputed issues arising under the plan.

The Surgeon General is directed to decentralize the administration of the program by giving priority and preference to the use of existing State and local agencies. Where no such arrangements have been made, the Surgeon General is directed to establish committees in each locality to aid in the administration of the program and to assure that the program will be adapted to local needs. Such committees shall include representatives of the insured population, doctors, hospitals, other agencies furnishing service under the program, and other persons informed on the need for, or provision of, health benefits. The Surgeon General is authorized to negotiate cooperative working arrangements with Federal, State, or local governmental agencies, and with private groups or individuals, to provide the benefits by utilizing their services and facilities on payment of fair and reasonable compensation. The health-insurance benefits may be furnished to noninsured persons such as needy persons receiving public assistance,

if appropriate arrangements are made to pay on their behalf the cost of services furnished to them.

The Surgeon General and the Social Security Board are directed to make studies and to report to Congress on dental, nursing, or other services not provided under the insurance system, and on services and facilities needed for the care of the chronic sick and for persons afflicted with mental diseases.

The Surgeon General is directed, with the advice of the National Advisory Council to administer grants-in-aid to nonprofit institutions and agencies, engaging in research or in undergraduate or post-graduate professional education. Such grants would be made for projects showing promise of making valuable contributions to the education, and training of persons in furnishing health-insurance benefits, or of making valuable contributions, with respect to the cause, prevention, or methods of diagnosis or treatment of disease or disability. Provision is made for giving preference to educational projects for returning servicemen seeking postgraduate education or training in medical, dental, and related fields. The sum available each year for such grants-in-aid would be 1 percent of the total expended for all social-insurance benefits exclusive of unemployment insurance or 2 percent of the amount expended for health insurance, whichever is less.

*Part B. Unemployment and Temporary Disability Insurance*

Part B establishes a new Federal unemployment insurance system administered by the Social Security Board. Unemployment benefits are payable for 26 weeks. If the funds available are deemed adequate, the duration of benefits may be extended to a maximum of 52 weeks, but the Board may require attendance at a training course as a condition for receiving such extended benefits. Weekly benefits are payable from \$5 to \$20 per week for single individuals. As in the case of old-age insurance benefits are increased for workers with dependents. The maximum benefit payable is \$30 per week in contrast to most existing State laws in which the maximum is between \$15 and \$20 per week. The waiting period is 1 week. Payment of benefits to eligible persons upon registration and continued reporting for work at the public-employment office or at training courses approved by the Board. Failure to report or to accept suitable work when offered is a ground for disqualification.

Insured workers who are certified as temporarily disabled, through illness or injury, are likewise eligible for the same benefits, after 1 week's waiting period, for a maximum duration of 26 weeks. In addition to the maximum duration for disability benefits, married women workers are entitled to weekly benefits, in the same amounts for 12 weeks of maternity leave.

TABLE 1.—Illustrative weekly unemployment and temporary disability insurance benefits under the bill.

Average Weekly Wage	Worker	Worker and Wife	Worker, Wife, and 1 child	Worker, wife and 2 more children
\$10 or less .....	\$ 5	\$ 6.50	\$ 7.50	\$ 8
\$20 .....	10	13.00	15.00	16
\$30 .....	15	19.50	22.50	24
\$40 or more .....	20	26.00	30.00	30

*Part C. Retirement, Survivors and Extended Disability Insurance*

Under this part of the bill, the present Federal old-age and survivors insurance system is broadened to include monthly cash benefits where the insured worker is totally

*continued on page 434*



**PRESENTATION OF DR. CHARLES V. CHAPIN AWARD  
OF THE CITY OF PROVIDENCE FOR 1945**

*(Left to right)* Dr. Roger I. Lee, of Boston, President-Elect of the American Medical Association; Hon. Dennis J. Roberts, Mayor of Providence; Dr. Francis G. Blake, Dean and Sterling Professor of Medicine, Yale University Medical School, the recipient of the award.



DOCTOR DEWOLF, YOUR EXCELLENCY, GOVERNOR MCGRATH, DOCTOR LEE, DOCTOR BLAKE, MEMBERS OF THE RHODE ISLAND MEDICAL SOCIETY AND GUESTS:

As I meet with you here tonight to extend the official greetings of the City of Providence, and to assist you in paying tribute to one of the world's greatest physicians, Dr. Charles V. Chapin, I wish to take the opportunity to felicitate the Rhode Island doctors, and through them the doctors of America, for their great achievements at home and abroad during the war years.

From every fighting front we have read of outstanding performances by the Men of Medicine who have travelled into the front lines to administer to the wounded and sick of our armed forces. Theirs has been a heroic task that called for true heroism with the chief recognition that of a job well done. We have read of reports from military leaders everywhere of the remarkable care that has been given our soldiers, and we have every reason to be extremely proud of our doctors at war, of whom 187 have come from this Society.

While the younger men for the most part have been called upon for active duty with the Army and Navy, the rest of you have worked unselfishly and untiringly to maintain the health of the people here at home. Yours, too, has been a stupendous task, imposing a great strain upon you physically to accept the additional burden. That you have done your work remarkably well is best attested by the fine record of civilian health here in the past four years.

And as we consider the success of modern medicine in combating the ills and ailments that beset mankind it is singularly fitting that we here in Providence should pay tribute tonight to one of your members, one of our citizens, whose keen mind and courage set the standards of public health leadership which has transformed American public health administration in the past quarter century.

It was he who suggested practically all the measures upon which modern public health practice with regard to communicable disease control is based — aseptic nursing technique, isolation in a hospital or a home under the supervision of a visiting nurse, a search for well carriers and more exact methods of diagnosis, including the use of the public health laboratory so as to reduce the number of missed cases; the reporting of cases to the health department and the keeping of accurate vital statistics for study and analysis, the provision of safe water and milk supplies; and the education of the public in the importance of personal cleanliness, especially handwashing.

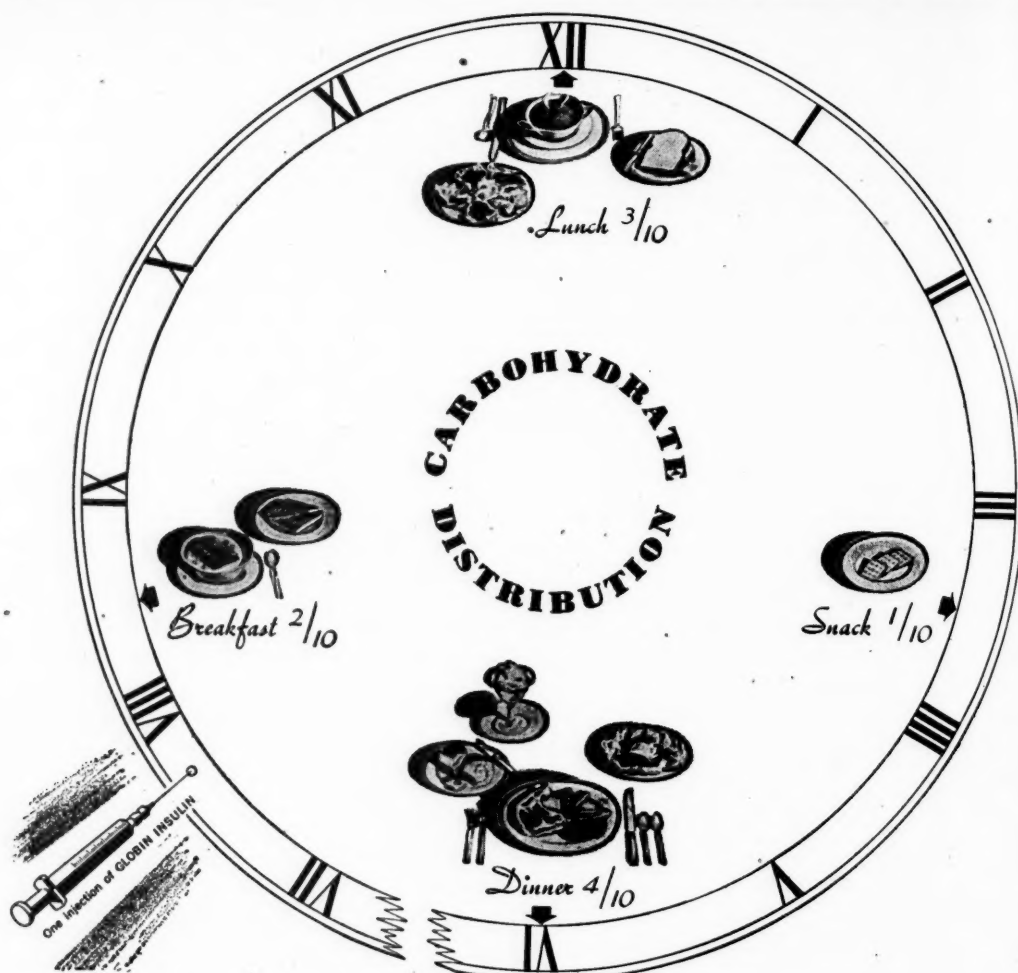
The City of Providence paid Dr. Chapin a great tribute while he was still alive by naming the municipal hospital in his honor. The Rhode Island Medical Society has enhanced his memory through the establishing of these annual Charles V. Chapin Orations to which Doctor Blake has made such an outstanding contribution in his discourse tonight.

It is most appropriate therefore, that the City Council of Providence, in behalf of the people of this city, join with the Rhode Island Medical Society on this occasion to pay this additional tribute to the memory of its Superintendent of Health for 48 years, one of the world's greatest contributors in the progress of public health, and the son of an illustrious physician-father who at one time was our Commissioner of Public Schools — Dr. Charles Value Chapin.

In behalf of the City of Providence, Dr. Blake, I award you the Charles V. Chapin Memorial Award presented by the City for your eloquent treatise on the subject of "Some Recent Advances in the Control of Infectious Diseases".

---

*Remarks by Honorable Dennis J. Roberts, Mayor of Providence, on the occasion of the presentation of the Charles V. Chapin Award of the City of Providence to Dr. Francis G. Blake of New Haven, at the 134th Annual Meeting of the Rhode Island Medical Society, at Providence, May 16, 1945.*



## DIABETES CONTROL *in tenths*

The physician planning a diabetic's diet with 'Wellcome' Globin Insulin will find it convenient to divide his patient's carbohydrate intake into tenths. Two-tenths for breakfast, three-tenths for lunch, one-tenth for a mid-afternoon snack, and four-tenths for supper will be found satisfactory for most patients.

Such a regime plus one injection of Globin Insulin daily will control most mild, moderate, and many severe cases of diabetes. Action is rapid in onset, sustained during daytime activity, and diminished at night—thus minimizing the likelihood of nocturnal reactions.

'Wellcome' Globin Insulin with Zinc is a clear solution and, in its relative freedom from allergenic properties, is comparable to regular insulin. Council accepted. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U. S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc.

'Wellcome' Trademark Registered



Literature on Request



BURROUGHS WELLCOME & CO. (U. S. A.) INC., 9 & 11 East 41st Street, New York 17, N.Y.

## HOSPITAL ASSOCIATION OF RHODE ISLAND

LEROY P. COX, *President*

FRANCIS C. HOUGHTON, *Secretary*

HELEN M. BLAISDELL, R.N., *Vice President*    WILLIAM SLEIGHT, *Treasurer*

ARTHUR H. RUGGLES, M.D., *Editor*

### VOLUNTARY HOSPITAL CONTROL

LEROY P. COX, *President, Hospital Ass'n of Rhode Island*

WHO controls our voluntary hospitals? Fellow citizens, you do—through your representatives. That is the way democratic organizations, including our state and federal governments function. This may surprise you as well as your representatives in your hospital corporation group.

If your hospital publishes a Year Book you should find a copy in your Public Library or one can be obtained at the hospital office. Listed in most Year Books are the names of the corporators, generally several hundreds in number. One or more corporators may live in your neighborhood, work in the same factory with you, belong to your church or club or be accessible to you in some other way.

The by-laws of most hospitals make the corporators a self-perpetuating group. Members of the Corporation propose the names of other persons in the community for membership. If there is no objection those persons are elected. In order that the group may not become too large there is sometimes a limitation as to the number elected at any one time. The corporators represent the public and in the last analysis determine the policy of the hospital. Many persons do not realize this fact.

Trustees, generally ten to twenty in number, are elected by the corporators from their group. The method of election varies. Sometimes an entire group is elected annually or may be elected every two or three years. The preferred way is to have one-third of the group elected every one or two years. This makes for continuity of program and effort.

The trustees or corporators also name committees for various projects, as well as name the Administrator, Director or Superintendent of the hospital. He or she in turn selects the hospital personnel.

Retracing the trail of responsibility to its origin we find the corporators to be the source of all authority. Since they elect the trustees they have

full power in all policies. Of course, they delegate power to the trustees and the trustees in turn to the Administrator. If the general public does not like some policy of the hospital there are many corporators who can speak concerning that policy. Meetings of the corporators are held annually or semi-annually. It is unwise to permit too frequent or sudden changes in hospital policies—as a hospital is a particularly long-lived organization.

Corporators, including trustees—too often only the latter—give much of their valuable time to the hospital but do not receive any financial remuneration. The satisfaction of knowing that they have done their best to alleviate the sufferings of the sick and afflicted is their only reward.

According to the by-laws of some hospitals, trustees are not permitted to sell to the hospital anything from their stores or services. This is an unnecessary rule but shows how far some corporators and trustees have gone to remove all chance for adverse criticism.

Voluntary hospitals are in existence under state charters which make it impossible for anyone to obtain dividends, if by any chance the hospital should show an excess of income over expense. This subject has at times been mentioned by persons not familiar with hospital work.

Under the present system of voluntary hospitals the responsibility rests entirely on the local citizens. Whether this might be changed under government control is a question which requires considerable thought. Would conditions be made better by governmental control, or rather, would hospital control not tend to be made into one standardized pattern attempting to cover all of the different standards and circumstances presented by the varying health problems in the many sections of this country? This is an important question upon which I would like to have your most careful consideration.

## SUMMARY OF PROVISIONS OF SOCIAL SECURITY AMENDMENTS

*continued from page 429*

disabled for 6 months or more before he reaches the retirement age. These benefits would be equal to those paid under old-age insurance, and in the same way would be increased for the worker who has a dependent wife, dependent children, or dependent parents. . . .

The bill also reduces from 65 to 60 years the age when women become eligible for retirement and widow's benefits. . . .

This section of the bill also liberalizes the existing provision of law which permits an individual to earn up to \$15 per month and still draw his insurance benefit. The amended provision increases this amount to \$25 per month. For blind persons this amount is increased to \$50 per month.

### *Part D. Trust Fund*

The bill creates a social insurance trust fund to which is transferred existing funds credited to the Federal old-age and survivors insurance system. The bill provides that all contributions are to be deposited directly in the trust fund. A board of trustees, composed as at present of the Secretary of Labor, the Secretary of the Treasury, and the Chairman of the Social Security Board, is established to hold the trust fund and make annual reports to Congress on the benefit payments and the status of the fund. The Secretary of the Treasury, as managing trustee, is authorized to invest the trust fund in United States bonds.

These contributions provided in the bill will be sufficient to pay all insurance benefits for several years after the end of the war, depending primarily upon employment conditions. Before that time it will be necessary to decide whether the contributions should be increased or the Government should contribute to the insurance system out of general revenues, or some combination of both.

### *Part E. Credit for Military Service*

The bill gives wage credits of \$160 per month to men and women in the armed forces for the entire period of their military service. The individual war veteran and his family would thus be insured for all social-insurance benefits provided in the bill, without deductions from his pay during military service. The cost of this protection is borne by the Federal Government out of general revenue.

### *Part F. Coverage of Insurance System*

This section extends coverage to all persons in industry and commerce (except railroad workers) under the entire social insurance system, including agricultural and domestic workers, seamen, and employees of nonprofit institutions (except ministers and members of religious orders). Self-employed persons (small businessmen, farmers, and professional persons) are covered under all insurance programs except unemployment and temporary disability insurance.

Present or future employees of State or local governments who are covered by existing pension systems specifically continue to be exempt, as under the present law. Employees of State or local governments who are not under existing pension systems may be covered (under retirement, survivors, extended disability, and medical insurance) by a voluntary compact between the Social Security Board and the appropriate State or local governmental unit.

Federal employees are not covered by the bill except hourly employees of the Tennessee Valley Authority.

## RHODE ISLAND MEDICAL JOURNAL

### *Part G. Social Insurance Contributions*

The bill provides for insurance contributions of 4 percent on employees and 4 percent on employers. The following table shows the allocation of contributions for each of the four insurance programs.

TABLE 4.—Propose social-insurance contributions under the bill.

Program	Em- ployer	Em- ployee	Total
	Per- cent	Per- cent	Per- cent
1. Retirement, survivors' and extended disability insurance .....	1.0	1.0	2.0
2. Medical care and hospitalization insurance .....	1.5	1.5	3.0
3. Unemployment insurance .....	1.0	1.0	2.0
4. Temporary disability insurance .....	.5	.5	1.0
Total contributions .....	4.0	4.0	8.0

Since the self-employed and employees of States and localities are not covered for unemployment and temporary disability insurance, but are covered only for retirement, survivors and extended disability benefits (for which 2 percent is charged) and medical care and hospitalization insurance (3 percent), their total contribution is 5 percent; in the case of the employees of States and localities (who may be covered on an optional basis if not already covered by their own pension system) half of this contribution is payable by their employer.

### *Part H. General Provisions*

The bill establishes a National Social Security Advisory Council, representing employers, employees, and the general public, to formulate policies on legislation and administration, and to investigate and make recommendations concerning coverage of various groups; the adequacy of benefits in relation to wage levels, cost of living, and other factors; methods of financing of the insurance system, and methods of providing incentives to beneficiaries for rehabilitation and employment.

The Social Security Board is directed to make provision, after consultation with the Surgeon General and the Office of Vocational Rehabilitation, for determination and certification of disability, and for the rehabilitation (medical and vocational) of disabled persons who are entitled to disability benefits and who may be assisted by such services so that they can return to gainful work. For these rehabilitation services, a sum equal to 2 percent of disability benefits is set aside from the trust fund.

## E. P. ANTHONY, INC.

### *Druggists*

178 ANGELL STREET  
PROVIDENCE, R. I.



---

## RHODE ISLAND STATE DENTAL SOCIETY

---

WILLIAM S. GEE, JR., D.M.D., *President*

JAMES C. KRASNOFF, D.M.D., *President-Elect*

NORMAN H. FORTIER, D.M.D., *Vice President*

ARTHUR J. JOHNSTON, D.M.D., *Editor*

CHARLES F. MCKIVERGAN, D.M.D., *Secretary*

GEORGE J. RACICOT, D.M.D., *Treasurer*

• PAUL E. COTE, D.M.D., *Librarian-Curator*

---

### DAVIS TECHNIQUE FOR TWENTY-YEAR PORCELAIN

1. Prepare interproximal cavities in spheroid shape rather than straight or square outline, using round burs for undercutting. This is to tie-in with tendency of silicates to "ball" and therefore break away from straight margins. Prepare mostly from labial, as lingual is to be supporting wall.
2. Apply rubber dam.
3. Sterilize with warm liquefied phenol crystals applied with loop.
4. Apply copalite with small loop.
5. Use stainless steel .002 matrix and insert between teeth; steel will not discolor porcelain.
6. Use wide-mouthed flat-sided bottle filled with ice water chilled to 45° as slab.
7. Defog with bare hands which leaves oil film on slab.
8. Place three portions powder in one heap on slab.
9. Drop first two drops liquid from dropper back into bottle and place next two drops on heap of powder.
10. Mix rapidly to heavy putty-like consistency, tap mix to bring gel to surface, and cover immediately with coverglass.
11. Pack cavity, using finger and back of matrix as support, then mallet filling to cavity margins with Davis points in malletor. (Dip points in cocoa butter.) Process of mixing and malleting must be completed in 3 minutes. Do not wrap matrix around filling. This will fracture the filling. When filling gets rubbery, stop malleting. Over-malleting spoils the color as does over-mixing.
12. Wait ½ hour; then trim and carve with Clevedent No. 11 D-P scaler, Clevedent No. 31 and No. 32 files. Never use disks or stones which cause heat. Approximating filling should be inserted separately. Coat with cocoa butter.
13. Remove dam, and instruct patient not to smoke cigarettes for 24 hours. Any brand of synthetic porcelain may be used; these fillings are not to be used on incisal angles or on lingual surfaces; they may be used successfully in labial and occlusal cavities. It is claimed for this technique that these fillings will not discolor, wash out, nor become chalky, that the colors will remain uniform, and that the fillings will outlast the ordinary synthetic insertions by many years, commanding a fee commensurate to that of a gold inlay.

*Paul C. Broderick*

PRESCRIPTION SPECIALISTS

Established 23 years

506 ELMWOOD AVENUE, PROVIDENCE

Williams 9661

**Curran & Burton, Inc.**

GENERAL MOTORS  
HEATING EQUIPMENT

**COAL**

**OIL**

TURKS HEAD BUILDING, PROVIDENCE

GA Spee 8123



---

## INDUSTRIAL HEALTH

### COMMITTEE ON INDUSTRIAL HEALTH

James P. Deery, M.D., *Chairman*; Charles L. Farrell, M.D.; Arthur E. Martin, M.D.; John F. Kenney, M.D.; William P. Buffum, M.D.

---

## NEW ENGLAND CONFERENCE OF INDUSTRIAL PHYSICIANS

The New England Conference of the American Association of Industrial Physicians and Surgeons, under the leadership of John F. Kenney, M. D., President, held a Spring Meeting on Wednesday, May 2, 1945, in Pawtucket, Rhode Island. The members of the Conference were the guests of J. & P. Coats (R. I.) Inc. and were welcomed to the Plant by Mr. J. Colby Lewis, Vice-President and General Manager.

Over eighty Members of the Conference, with Members of the Rhode Island Society of Industrial Physicians and a splendid representation of the Rhode Island Industrial Nurses Club enjoyed an excellent luncheon at 12:30 P. M., following which the formal program was carried out in the Auditorium of the Company.

In addressing his remarks to the Conference, Mr. Lewis noted a brief history of the Plant and spoke of the fact that the Members of the Conference were guests of the largest thread company in the world, and he also pointed out that the Plant was making a number of war items of vital importance. He noted the appreciation that industry felt to the medical profession for helping to get injured workers returned to their vital jobs as quickly as possible. He stressed the teachings of safety which industry, and particularly his Plant, had instituted and pointed with considerable pride to the record which this Company holds. He pointed out the necessity for continued application of safety principles in all types of work and felt that it was due to the cooperation between the management and the worker in this particular Mill that the safety record had held up as well as it has and hoped that the continuation of such cooperation would assist in cutting down lost time due to accident.

Dr. John E. Donley, Medical Director of the new Curative Center in the State of Rhode Island was the next speaker. He pointed out that the Curative Center will treat only injured workers in industry and has no connection with any veteran or other class organization. The Curative Center is to be used purely by injured workers who are referred to it by their own physicians. The value of this will be that it will have a great number of varying

therapeutic measures that can be applied for the benefit of certain patients, who otherwise would be unable to receive such therapy at the hands of an individual physician, and when these patients are improved they will be returned to their occupation through and only through their original physician. This Curative Center is really a branch of the State Department of Labor and as such Dr. Donley feels that it will be of great and lasting value in assisting those who have been injured and come under the Workmen's Compensation Act of the State.

Dr. Zambarano, Superintendent of the State Sanatorium at Wallum Lake, spoke about tuberculosis in industry and the efforts which he was endeavoring to put into effect for the discovery, prevention and spread of this disease. He felt that due to lack of regular physical examinations by the general public much more tuberculosis got past the stage where it was readily curable to the point where too many cases become hopeless. He felt that an x-ray of the chest of every worker in industry should be made in an endeavor to check easily cases that can be readily cured, as well as to prevent later cases from contaminating fellow workers. He felt that in the future, if the ideas which he has in mind can be carried out throughout this State, tuberculosis will be one of the rarest of diseases among our local population and he hopes that every village and hamlet will before long be equipped with means to discover and assist in the treatment of tuberculosis.

*continued on page 445*

### INDUSTRIAL MEETING — JUNE 28

A combined meeting of the New England Conference of Industrial Physicians, the Rhode Island Society of Industrial Physicians and Surgeons, and the Rhode Island Industrial Nurses' Club will be held at the State Curative Centre on Blackstone Boulevard on the afternoon of June 28.

An interesting program of local and out-of-town speakers is scheduled, and all in attendance will also have the opportunity to inspect the new rehabilitation centre recently opened. A notice of the complete program for the meeting will be sent to all physicians.



R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

*Now in use on the battle fronts, for speedy evacuation of wounded from nearly inaccessible areas, is this Helicopter with "capsule" stretchers attached to sides*



**W**HEREVER our soldiers are fighting, Army medical men have established a speedy life line for wounded. So fast and so efficient is it that often the wounded are under the care of skilled medical officers *within a matter of mere minutes!*

In this stepped-up tempo of war, however, the Army doctor finds little "time out" for himself. When there is a "break" in his long hours, his relaxation may be limited to a few pleasant moments with a cigarette... very likely a Camel, for Camels are such a big favorite with men in all the services.

**Camel**—costlier tobaccos





HONORABLY



DISCHARGED

*(Know and recognize the emblem above. The wearer of it has served in our Armed Forces and has received his or her honorable discharge. As promptly as our Rhode Island doctors notify us of their return to civilian practice from duty with the armed forces their names will be published in the JOURNAL under this insignia. The names listed below are from our current file. Corrections or additions are requested. THE EDITORS)*

E. WADE BISHOP, M.D., 454 Angell St., Providence  
 G. EDWARD CRANE, M.D., 223 Thayer St., Providence  
 CHARLES S. DOUCET, M.D., 615 Broad St., Central Falls  
 WALTER R. DURKIN, M.D., 73 Dixon St., Providence  
 JAY N. FISHBEIN, M.D., 221 Angell St., Providence  
 ALBERT E. GEREMIA, M.D., 172 Pocasset Ave., Providence  
 ARTHUR E. MARTIN, M.D., 101 Waterman Ave., Providence  
 MARGARET B. ROSS, M.D., 26 Holbrook Ave., Rumford  
 GUSTAF SWEET, M.D., 105 Waterman St., Providence  
 DANIEL V. TROPPOLO, M.D., 380 Broadway, Providence  
 HOWARD W. UMSTFAD, M.D., 188 Main St., Pawtucket  
 ROBERT L. BESTOSO, M.D., 135 Touro St., Newport  
 MARCO COLAGIOVANNI, M.D., 288 Broadway, Providence  
 SAMUEL NATHANS, M.D., Hope Valley  
 MATTHEW W. ROSSL, M.D., 784 Park Ave., Cranston  
 THOMAS P. SHERIDAN, M.D., 118 Prospect St., Pawtucket

### V-E DAY AND THE WAR DOCTOR

The ending of hostilities in Europe means that the doctors, nurses, technicians and other personnel who comprise the Army Medical Department will now begin an even bigger job than they have been doing, which means there is no immediate prospect for the general release of personnel, Major General Norman T. Kirk, The Surgeon General, declared on V-E Day.

The Medical Department, he pointed out, not only must continue to care for the sick and wounded but must make immediate preparations for the redeployment of troops to the Pacific or this country.

One of the biggest tasks will be to give physical examinations to some 3,500,000 soldiers before they leave Europe. In addition, a goal of 90 days has been set in which to evacuate the sick and wounded from the European Theater to this country. Then there will be the final matter of redeploying the Medical Department personnel and equipment.

Soldiers whose condition necessitates a medical discharge will be given further treatment and necessary examinations in the United States. All soldiers, prior to discharge from the service, will be screened for tuberculosis, syphilis and other diseases, and for possible strains and other physical defects. Thus hospitals here will probably be operating at capacity with a critical need for medical personnel for many months to come.

### MILITARY ANNOUNCEMENTS

#### ASSIGNMENTS

LT. (s) FRANCIS E. HANLEY, MC, USNR, U. S. Naval Hospital, Newport, Rhode Island  
 LT. (s) EDWARD V. HEFFERNAN, MC, USNR, U. S. Naval Hospital, Newport, Rhode Island

#### TRANSFERS

CAPT. IRVING A. BECK, MC, 43 Session Street, Providence 6, Rhode Island  
 MAJOR HENRY A. CAMPBELL, MC, 0443617, APO 562, c/o Postmaster, New York, N. Y.  
 LT. COMDR. JAMES H. COX, MC, 162 Academy Avenue, Providence, Rhode Island  
 CAPT. JOHN A. DILLON, MC, 77 Chestnut Avenue, Waterbury, Connecticut  
 CAPT. THOMAS A. EGAN, MC, 0315101, APO 230, c/o Postmaster, New York, N. Y.  
 CAPT. I. GERSHMAN, MC, APO 403, c/o Postmaster, New York, N. Y.  
 CAPT. FRANK C. JADOSZ, MC, 1072nd, B. N. Sq. E., Fort Logan, Colorado  
 LT. (jg) LLOYD LAGERQUIST, MC, USNR, c/o Fleet Post Office, San Francisco, California  
 COL. HERMAN A. LAWSON, MC, 12 Everett Avenue, Providence, Rhode Island  
 CAPT. LOUIS D. LIPPITT, MC, AAF, P.D.C. No. 1, Ritz-Carlton Hotel, Atlantic City, New Jersey  
 CAPT. EDWARD B. MEDOFF, MC, 0553094, APO 411, c/o Postmaster, New York, N. Y.  
 MAJOR ROBERT G. MURPHY, MC, Ward 139, Lovell General Hospital, Fort Devens, Mass.  
 MAJOR WALLACE J. PIANKA, MC, SCU 1915, Madigan Convalescent Hospital, Fort Lewis, Washington  
 LT. EDWARD F. RUHMANN, MC, USNR, U.S.N. Torpedo Boat Sq. Tng. Center, Portsmouth, Melville, R. I.  
 CAPT. EDWARD R. THOMPSON, MC, c/o Postmaster, New York, N. Y.  
 CAPT. MARK A. YESSIAN, MC, APO 920, c/o Postmaster, San Francisco, California

#### PROMOTIONS

LT. EDWARD B. MEDOFF to Captain  
 CAPT. ARNOLD PORTER to Major  
 LT. JACOB REICH to Captain

# America's Finest Milk . . .



**HOODSEALED FOR YOUR PROTECTION**

*Produced in Rhode Island  
under the supervision of the*

**MEDICAL MILK COMMISSION OF PROVIDENCE**

**“It's Certified”**

**CORRECTED MONTHLY AVERAGES OF CERTIFIED MILK FOR 1944**

	CHERRY HILL Distributed by H. P. HOOD			FAIROAKS				HAMPSHIRE HILLS Distributed by WHITING			WALKER-GORDON Distributed by H. P. HOOD CO. - WHITING MILK CO.					
	Pasteurized							Pasteurized			Vit. D. Pasteurized			Pasteurized		
	B.F.	T.S.	Bac- teria per C.C.	B.F.	T.S.	Bac- teria per C.C.	Pas- teur- ized	B.F.	T.S.	Bac- teria per C.C.	B.F.	T.S.	Bac- teria per C.C.	B.F.	T.S.	Bac- teria per C.C.
January.....	4.1	12.91	36	4.6	13.98	1,550	25	4.4	13.22	12	3.8	12.69	249	3.9	12.73	159
February.....	4.1	12.89	31	4.4	13.69	1,785	32	4.7	13.93	14	3.9	12.99	139	3.9	12.87	197
March.....	4.	12.84	16	4.2	13.30	1,261	28	4.6	13.93	29	3.9	12.77	36	3.9	12.83	80*
April.....	3.9	12.56	25	4.4	13.43	1,681	138	4.5	13.61	11	3.6	12.33	41	3.6	12.40	162
May.....	4.1	12.79	37	4.5	13.51	2,694	122	4.5	13.59	19	3.8	12.25	76	3.6	12.06	36
June.....	3.8	12.47	8	4.2	13.20	2,622	84	4.2	13.12	28	4.0	12.76	12			
July.....	3.9	12.27	134	4.2	12.94	3,650	225	3.9	12.69	198	4.0	12.77	117			
August.....	3.7	12.17	117	4.2	13.00	3,770	377	3.9	12.59	283	4.0	12.76	63			
September.....	3.6	12.05	99	4.0	13.08	4,950	79	4.1	12.87	83	4.0	12.89	105			
October.....	3.8	12.53	61	4.3	13.27	2,945	16	4.0	12.87	65	4.0	11.83	28			
November.....	3.9	12.59	9	4.3	13.43	4,225	40	4.0	12.81	59	4.1	13.13	16			
December.....	3.9	12.48	14	4.2	13.08	3,750	33	4.1	13.01	57	4.1	13.05	22			
Yearly Average.....	3.9	12.54	49	4.3	13.32	2,906	99	4.2	13.18	72	3.9	12.68	75	3.7	12.57	126

## INDUSTRIAL PHYSICIANS CONFERENCE

*continued from page 441*

His paper was discussed by Dr. Daniel Lynch, Medical Director of the New England Telephone & Telegraph Company of Boston, who agreed in part with Dr. Zambarano's ideas and expressed himself as wholeheartedly in favor of any system of checking up on individuals in industry which would assist in controlling the disease. He spoke of the various methods which he uses in his Company to check and assist in curing the disease when discovered among the workers of the Telephone Company.

Dr. Vincent J. Ryan of Providence spoke on skin conditions in industry. He felt that there were an enormous number of skin rashes which developed while the employee was at work and which were not due to anything that they handled in the course of their jobs; on the other hand he did feel that greater care should be exercised in testing all solutions and powders and other equipment to determine possible effects on the skin before being put into and used in routine production. He spoke of a number of skin diseases that develop which have no bearing on the materials which the individual is handling and he discussed how far the Compensation Law should be exercised in the payment for disability.

Dr. Henry B. Moor, Chief Surgeon of the Memorial Hospital at Pawtucket, and Medical Director of the Gorham Mfg. Company, spoke on severe burns and their treatment. His very clear, concise and able talk was illustrated by lantern slides. Everyone connected with the medical profession who listened to his very lucid description of treatment could not help but be impressed by the study and care which Dr. Moor has given this condition.

In closing the program, Dr. Kenney again expressed to Mr. Lewis the thanks for the Conference and the many courtesies extended to the doctors and nurses who attended.

Many favorable comments were made on the very fine exhibit of the processes through which the cotton went to become thread, as well as the showing of various types of war work in which the Company is engaged.

Following the Meeting at the Mill, the Members of the New England Conference and the speakers were entertained at dinner at the Pawtucket Golf Club. At the head table, where Dr. Kenney presided, Mr. J. Colby Lewis, Mr. Emerson M. Bullard, Assistant General Manager, Mr. Charles H. Smith, Secretary, and invited speakers were present.

Among the guests present at the Meeting from out of the State were the following:—Dr. Daniel Lynch, New England Telephone & Telegraph Co., Boston, Mass. Dr. J. Allan Thompson, Secretary

& Treasurer, Boston, Mass.; Dr. George E. Morris, Boston, Mass.; Dr. L. R. Daniel, Hood Rubber Co., Watertown, Mass.; Dr. Clarence E. Burt, New Bedford, Mass.; Dr. Edwin Fuller, Jr., Bath Iron Works, Bath, Maine; Dr. J. R. Knowles, Boston & Maine Railroad, Boston, Mass.; Dr. James I. Rabinowitz, New England Power Co., Boston, Mass.; Dr. Harold L. Higgins, Newton, Mass.; Dr. Theodore L. Storey and Dr. Marshall Colcord, both of the American Optical Co., Southbridge, Mass.

REPORT OF A CASE OF EMPYEMA  
TREATED WITH PENICILLIN*continued from page 426*

I hereby wish to express my gratitude to Dr. M. Chapien for the privilege of following this case along.

## REFERENCES

- <sup>1</sup>Butler, E. C. B., Perry, Kenneth M. A. and Valentine F. C. O. Treatment of Acute Empyema with Penicillin. *British Medical Jr.*, August 5, 1944.
- <sup>2</sup>Tillett, Wm. S., Cambier, Margaret J. and McCormack, James E. The Treatment of Lobar Pneumonia and Pneumococcal Pneumonia with Penicillin. *Bulletin of the New York Academy of Medicine*, March 1944.
- <sup>3</sup>Keefer, Chester S., et al. Penicillin in the Treatment of Infections, A Report of 500 cases. *Jr. Amer. Med. Ass'n.* August 28, 1943.
- <sup>4</sup>Bennett, T. I. and Parkes, Trevor. Penicillin in Sulphonamide Resistant Pneumonias with Special Reference to Staphylococcal Infection and Empyema. *The Lancet*, March 4, 1944.

**Armand L. Lanoie**

REGISTERED OPTICIAN

Prescriptions for eyeglasses  
carefully filled. A complete  
line of optical accessories.

**ZENITH**

Radionic Hearing Aid

**Tilden-Thurber**

Westminster Street at Mathewson, Providence



***"suddenly . . . life was worth living"***\*

In depressed patients, Benzedrine Sulfate is virtually unique in its ability to banish apathy, subjective weakness, and despondency . . . to restore mental alertness, enthusiasm and the capacity for work . . . to increase the sense of energy . . . and to reawaken the zest for living.

The quotation which heads this page provides, out of the author's own experience, striking testimony to the dramatic value of Benzedrine Sulfate in the relief of simple depression, with its associated symptoms of anhedonia, chronic fatigue and retardation.

\*Reiter, P. J., Experience with Benzedrine, Ugeskr. f. Læger, 99:459-460, 1937.



## **BENZEDRINE SULFATE TABLETS**

Racemic amphetamine sulfate, S.K.F.

**SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.**



## BOOK REVIEW

*DOCTORS AT WAR.* Edited by Morris Fishbein, M. D. E. P. Dutton & Co., Inc. 418 p. illus. 1945.

*Doctors At War* is an extremely interesting and fascinating book telling of the magnificent work of the American doctors in every phase of medical warfare in World War II. It is comprised of sixteen reports by leading authorities describing in detail the multitudinous accomplishments of their respective branches of service. Along with these stirring accounts are vivid photographs of some of our hospitals and doctors at work, plus many interesting explanatory charts and diagrams.

Emphasis is placed upon the comparison of sick and wounded men of the last war and World War II. Preventive medicine, as described by Brigadier General James Stevens Simmons, M. D., Chief of the Preventive Medicine Service, United States Army, has played a tremendous part in helping to impede war's epidemics by the maintenance of good health in the services, the elimination of sanitary and other health hazards and the control of infectious diseases. There have been hundreds of research projects and within the past few years three great contributions have been made: 1) blood sub-

stitutes, especially the use of plasma; 2) the discovery of penicillin, and 3) the development of the effective new insect repellents, particularly D. D. T. Out of all the research that is being done have come vital discoveries that will be beneficial to mankind for many years to come.

Military agents that are being utilized in this war are far more disastrous than those ever used before, but in spite of this fact the rate of survival among the wounded is much higher than it has ever been in previous wars. One cannot help but be impressed with the account of "The Army Doctor in Action" which is related by Major General Norman T. Kirk, The Surgeon General of the United States Army. The doctors of this country have responded wholeheartedly to the call to arms and by the end of 1944 there were more than 40,000 medical officers in the Medical Department of the Army. Each man had to be thoroughly trained into military custom, which in itself was a tremendous task, but the work they perform is really outstanding. It is inspiring to note the following figures:—"The annual death rate per 1,000 men for all diseases in the army, excluding surgical conditions, was lowered from 15.6 in the last war

*continued on next page*

*It fills the need . . .*

## FOR A SOFT CURD MILK

Proper homogenization produces a very low-tension curd and at no sacrifice of the milk's normal calcium and phosphorus.

- For a milk acceptable to finnick digestive systems . . .
- For a key food for expectant and nursing mothers . . .
- For the most important item in infant feeding . . .
- For a war-time replacement food as well as a basic food . . .

**PRESCRIBE**

**GRADE A HOMOGENIZED MILK**

*Produced by*

**A. B. Munroe Dairy**

Established 1881

102 Summit Street, East Providence, R. I., Telephone East Providence 2091

## DOCTORS AT WAR (Book Review)

*continued from preceding page*

to only 0.6 in this war." And the work of the surgeons is amazing to contemplate. "As of 1944, the over-all mortality rate among the wounded in the army was approximately 3 per cent, which means that 97 out of every 100 soldiers in battle have been saved, as contrasted with the figure of more than 8 per cent in the last war." Not only have a great many more lives been saved, but the surgeons have performed "near-miracles" in reconstructive and rehabilitative programs.

The work of the Navy doctor is vividly portrayed by Vice Admiral Ross T. McIntire, the Surgeon General of the United States Navy, and there are stirring reports of the terrific undertaking for preparing for D-Day and the caring for the wounded at Guadalcanal, Tarawa and other places where fighting is taking place.

Great credit is given to the American Red Cross which is carrying on so many noteworthy activities here and overseas, such as the Blood Donor Serv-

## RHODE ISLAND MEDICAL JOURNAL

ice, recruitment of nurses, recreational and assistance services and many other important and beneficial services without which it would be almost impossible for the medical profession to carry out its work to such a high degree.

I have only briefly described a few of the subjects discussed in this book and we must not forget the gigantic task of recruiting men to fight, the work of the United States Public Service, The Air Forces and the Veterans Administration to mention only a few more topics so aptly recorded.

*Doctors At War* is a truly inspirational book which will be thoroughly enjoyed by the layman as well as the doctor. For those of us who have members of our family fighting in the services, it is most reassuring to know just what is being done to care for them mentally as well as physically, and we certainly give our sincere thanks and deep appreciation to the medical profession for the admirable and miraculous work which they are performing every day, and to the author for doing such a splendid job of editing this very fine book.

HELEN R. SHERER

**Pure..**  
**Wholesome..**  
**Refreshing**

Safeguarded constantly by scientific tests, Coca-Cola is famous for its purity and wholesomeness. It's famous, too, for the thrill of its taste and for the happy after-sense of complete refreshment it always brings. Get a Coca-Cola, and get the feel of refreshment.



## DISTRICT SOCIETY MEETINGS

### KENT COUNTY MEDICAL SOCIETY

Officers elected for the Kent County Medical Society for the current year are as follows:

*President* — LEO H. DUQUETTE, M.D.  
*Vice President* — JEANNETTE VIDAL, M.D.  
*Secretary* — JOSEPH K. HARROP, M.D.  
*Treasurer* — JOHN A. MACK, M.D.  
*Delegate* — ROCCO ABBATE, M.D.  
*Councillor* — ROCCO ABBATE, M.D.

### PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held on Monday, May 7, 1945. The meeting was called to order at 8:30 P. M. by President B. Earl Clarke.

The Secretary reported for the Executive Committee as follows:

At its recent meeting the Executive Committee adopted the following recommendations:

That the Association pay all expenses incidental to the participation of guest speakers at scientific meetings of the Association.

That the Committee on Entertainment be instructed to decide on the feasibility of a golf tournament for the Association members, and that the Association appropriate \$25 for use by the Committee in connection with arranging a tournament, if it is deemed advisable to have one.

A motion was adopted to accept the report of the Executive Committee.

Dr. Edward S. Cameron, Chairman of the Committee on Smoke Abatement, read a report of that committee. The complete report is as follows:

"This committee is able to report the following action since the March 5, report to this Association.

"On March 19, 1945 a dinner meeting was held at the University Club, at which, eighteen Civic Group Representatives discussed the Smoke Abatement problem with the committee. Mr. Philip S. Mancini, Providence City Engineer, and Drs. Alex. M. Burgess and B. Earl Clarke were the speakers. A general discussion followed, and it was finally decided that the chairman appoint a committee, among those present, to meet with Drs. Clarke and Cameron at a later date to work out a plan, and to report back a proposed plan of action to the group.

"The following members were selected as members of this planning committee:

Miss Alice W. Hunt, Pres. Consumers' League of R. I.  
 Miss Georgia B. Lewis, Pres. R. I. Fed. of Bus. & Prof. Women's Clubs.

Mr. Edward Winsor, Vice Pres., Prov. Chamber of Commerce

Mr. George Hurley, Chairman, Prov. City Plan Commission

Mr. Harry C. Rankin, Pres. Prov. Engineering Society  
 Mr. Albert Harkness, Pres. R. I. Chapter Amer. Institute of Architects

Dr. Alexander Burgess

"On April 16, 1945, a meeting of this planning committee was held at the University Club. Dr. Clarke presided at this meeting in the absence of Dr. Cameron. It was decided after a general discussion that a good improved City Ordinance relating to the control of Air Pollution should be introduced. Plans for a larger Civic Group Committee to take up this problem could be carried through if no improvement in the conditions were observed after a reasonable period of observation.

"It was a satisfaction to the committee that considerable interest was shown by all members present at various meetings. It was stated by Mr. Winsor of the Providence Chamber of Commerce that in a previous questionnaire sent to the Chamber of Commerce members the problem of Smoke Abatement was rated first for action toward improvement."

A committee consisting of Dr. Edward S. Cameron, Dr. Peter Pineo Chase, and Anthony V. Migliaccio submitted a resolution to the Association concerning the pollution of the rivers of the state and Narragansett Bay. The motion was adopted.

"The members of the Providence Medical Association, cognizant of the widely known contamination of the waters of our rivers and bay, are concerned over the threat to Public Health, and the economic loss, caused by the increasing damage to our fisheries. Also they realize that most of our citizens are deprived of health giving advantages as the filth of the adjacent waters and beaches make it impossible to enjoy the wonderful recreational facilities which Nature has placed here. Bathing, yachting, fishing, hunting, and other healthful sports are affected.

"Like all good citizens they also deplore the decimation of water fowl through oil pollution and last but not least the deterioration of our bay and rivers from an aesthetic viewpoint. The economic loss because of the lower valuation of lands bordering the bay should be noted here.

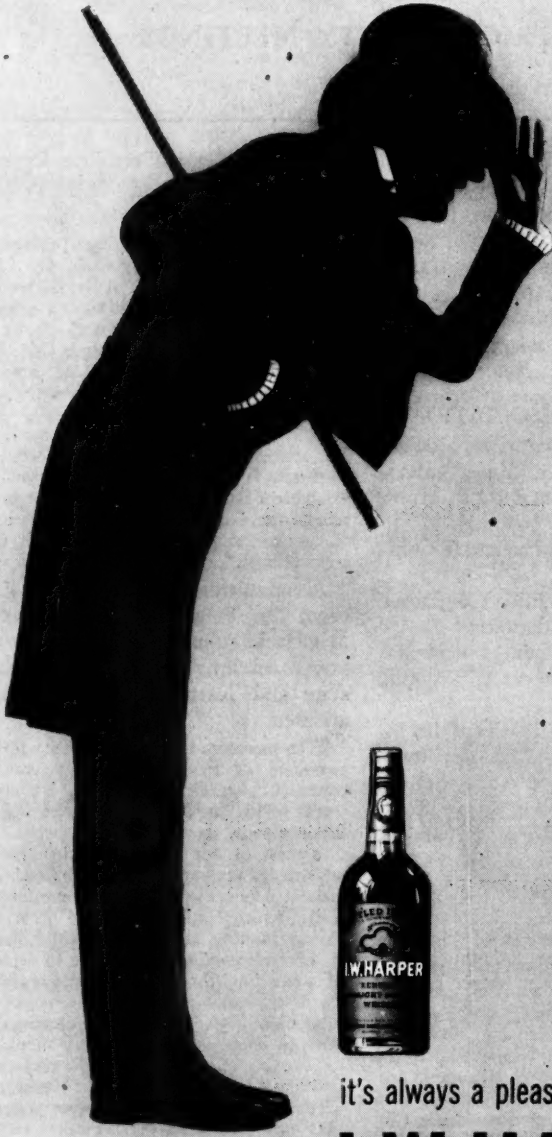
"The Association commends Governor Howard McGrath for his interest and initiative in the State's program dealing with purification of our waterways. They feel that enforcement of the laws now on our statute books, and enactment of others, which may be necessary, will accomplish much toward desired results.

"Therefore, be it resolved: that the Providence Medical Association give its whole hearted approval and recommendation to action by our State Government toward purifying the waters of the rivers and bay of the State of Rhode Island."

The President announced the appointment of a committee consisting of Drs. Jesse E. Mowry and Roswell Wilcox to prepare the Association's tribute to the late Dr. Carl Doten.


The President announced the appointment of the Association's War Veterans Committee con-

*continued on page 453*



... may I suggest you  
buy more  
U. S. War Bonds today?

*J. W. Harper*



it's always a pleasure

**I.W. HARPER**

the gold medal whiskey *since 1872*



Distilled in peace time and Bottled in Bond  
under the supervision of the U. S. Government.

Kentucky Straight Bourbon Whiskey, Bottled in Bond, 100 Proof, Bernheim Distilling Co., Inc., Louisville, Kentucky.



## DISTRICT SOCIETY MEETINGS

*continued from page 451*

sisting of: Dr. Albert H. Jackvony, Chairman; Dr. Paul C. Cook, Dr. Frank W. Dimmitt, (officers of the Association); Dr. Henry Joyce and Dr. Kalei K. Gregory (Hospital representatives); Dr. James P. Deery (Industrial medicine interests); and Dr. G. Edward Crane and Dr. E. Wade Bishop (Doctor-veterans).

The Secretary announced that the Executive Committee recommended for active membership in the Association Dr. A. A. Savastano and Dr. Paul J. Votta. It was moved, seconded and passed that both doctors be elected.

The President introduced as one of the speakers of the evening, Dr. Roland Hammond, who spoke on "Hugh Owen Thomas: The Apostle of Rest".

Hugh Owen Thomas was a member of the seventh generation of bone setters in the Thomas family. His father, however, saw the handwriting on the wall and sent his five sons to medical school at the University of Edinburgh. Dr. Thomas practiced principally among the dock workers and poor of Edinburgh. He eventually had a hospital of his own. His orthopedic appliance workshop, a picture of which was shown, certainly seemed the equal of any one might find today. Dr. Thomas treated an unbelievably large number of patients, working about 16 hours of every day with practically never any vacation.

He invented clever appliances, the best known perhaps being the Thomas splint. This splint was introduced into the Armies of the Allies by Dr. Thomas' nephew, Sir Robert Jones at the time of the first World War.

Dr. Ridlon of Chicago visited Dr. Thomas in Edinburgh in 1887, and returned to America to spread some of Thomas' teachings among the profession of this country. Dr. Thomas was apparently the first to advise immobilization of inflamed joints.

Dr. Clarke introduced Dr. Orville T. Bailey of Boston who spoke on "The Uses of Purified Human Fibrinogen and Thrombin in Medicine and Surgery".

Dr. Bailey reported on the factionation of human plasma which was accomplished as an urgent problem, the solution of which was requested by military authorities early in the present war. For emergency use, under conditions where small volume was necessary because of air transportation, etc. the use of serum albumin was adopted because it reduces transportation space to about  $\frac{1}{8}$  as compared with whole plasma.

Fibrin can be prepared in the form of spongy like foam, as a resilient film, or it can be plasticized. So far no great use has been found for the plastic

preparation. Use of the foam and film has been chiefly in surgery of the central nervous system. Fibrin used with thrombin makes an excellent hemostatic and has many advantages over previous methods, such as the use of muscle tissue. Space prevents a detailed discussion of Dr. Bailey's very interesting paper. However, the information given us on this very new subject was of great interest. Questions were asked by Drs. Porter, Corvese, Jackvony and others.

The meeting was adjourned at 10:35 P. M.

Collation was served.

Respectfully submitted,

FRANK W. DIMMITT, M.D., *Secretary*

## PAWTUCKET MEDICAL ASSOCIATION

The monthly meeting of the Pawtucket Medical Association was held in the Nurse's Auditorium of the Memorial Hospital, Friday evening, May 25. A buffet supper was served. Afterwards a short business meeting was held.

Dr. Gilbert Haggart, chief of the Orthopedic Service of the Lahey Clinic, spoke on the origin and treatment of low back pain. Doctors John E. Donley and G. Edward Crane, of Providence, spoke on the orthopedic and neurologic viewpoints. General group discussion followed.

## OXYGEN

CARBON DIOXID-OXYGEN  
MIXTURES

## HELIUM-OXYGEN MIXTURES

## NITROUS OXID

## CARBON DIOXID

## CYCLOPROPANE

\* \* \*

## OXYGEN TENTS, FACE MASKS

For Sale or For Rent

## CORP BROTHERS

Dexter 8020

24 Hour Service

**Hot weather  
presents no  
problem when  
Lactogen  
is used for  
infant  
feeding  
... because**



...when refrigeration is not available, each feeding may be prepared separately. The doctor can always advise the mother to prepare individual LACTOGEN feedings whenever the baby is ready for his bottle. Preparing each LACTOGEN feeding just before feeding time safeguards the baby against the danger of nutritional upsets caused by bacteriological changes in the formula.

### **EASY TO PRESCRIBE**

#### **LACTOGEN + WATER = FORMULA**

<b>1 LEVEL TABLESPOON</b>	<b>2 OUNCES</b>	<b>2 FLUID OUNCES</b>
<b>40 CALORIES</b>		<b>20 CALORIES</b>
<b>(APPROX.)</b>		<b>PER OZ. (APPROX.)</b>

No advertising or feeding directions except to physicians. For feeding directions and prescription pads, send your professional blank to

**Nestlé's Milk  
Products, Inc.**

155 EAST 44TH ST., NEW YORK, 17, N. Y.

## THROUGH

*the Microscope*

WHILE the hotels of Providence were jammed to capacity with the advent of the start of the horse racing season, and while undoubtedly a similar situation prevailed in other parts of the country, the Committee on War Conventions of the Office of Defense Transportation in Washington denied permission for a meeting of the House of Delegates of the American Medical Association in Chicago in July . . . . Perhaps the AMA should stop asking for permission and plan to stage a conference on the vital problems of American medicine and health between the fifth and sixth races at Lincoln Fields as soon as that track opens its gates.

\* \* \*

With popular literature crammed with reports on what to do and what not to do about the neuro-psychiatric veterans, we are pleased to note that civilian consultants called in to assist the Surgeon General and his staff include our own Dr. Arthur H. Ruggles, of Butler hospital, whose knowledge of psychiatric problems is second to none in the country.

\* \* \*

Rhode Island has a big stake in the future development of industrial health by reason of the fact that we are undoubtedly the most highly industrialized area in the country. Hence the announcement of the publication of a new manual prepared by the Occupational Health Division of the Preventive Medicine Service, Office of the Surgeon General, merits more than passing interest here. As a guide in standardizing the medical program of dispensaries in Army industrial installations the manual has been acclaimed by the Civil Service Commission and several other interested organizations as a distinct forward step in industrial medicine generally.

\* \* \*

Hearings before the Senate Committee on Military Affairs on the Ellender bill calling for deferment of Premedical and Predental students were concluded on May 1. No further action was taken on the bill, and a report is current that a companion

bill will be introduced in the House of Representatives . . . . . Meanwhile the plight of America as regards the training of replacements for technical men called into the armed forces was characterized as "scientific suicide" by Dr. Charles Allen Thomas, director of Monsanto Chemical Company's central research laboratories at Dayton, and also a director of the American Chemical Company. According to scientist Allen "American college graduating classes have been reduced to 10% of their former level. Our Selective Service System has not only virtually eliminated the training of young scientists, but also has made it very difficult for industries and universities to retrain young men already trained".

\* \* \*

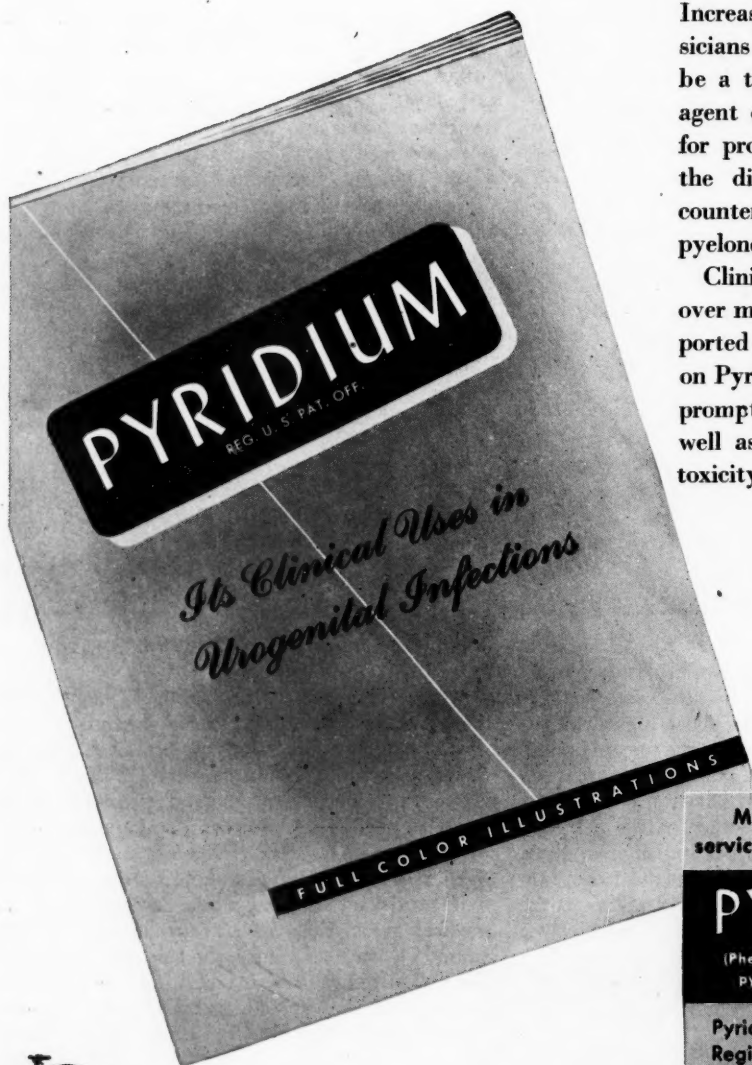
As we become concerned about the food shortage we are faced with figures released by the War Food Administration to show that in normal times Americans waste 125 million pounds of food daily from farm to table . . . . . Such information is little help in abnormal times . . . . . Meanwhile five bills dealing with school lunch legislation have been introduced in the first session of the 79th Congress.

\* \* \*

It has remained for California to demonstrate the importance of highly-trained executives in the service of county and state medical organizations. At its 74th annual session, convened in Los Angeles in May, a resolution was adopted to provide for the establishment of an Advisory Planning Committee to be composed of lay employees of the various medical bodies. The personnel of the committee will consist of the executive secretaries of the medical associations of California, Los Angeles County, Alameda County, the associate counsel of the California Medical Association, the lay representative of the Council, and the executive secretary of the Public Health League of California. The Committee was instructed by the Delegates to study the economic and health factors involved in medical and hospital care problems, to report to the Council in respect to such matters, outlining actions to be taken with reasons therefor.

continued on page 459

## For the Busy Physician



*This concise booklet, presenting the essential data on the action and uses of Pyridium, together with several full color plates illustrating the pathologic changes in urogenital infections, will be sent to you on request.*

Increasing numbers of busy physicians are finding Pyridium to be a thoroughly dependable agent on which they may rely for prompt, gratifying relief of the distressing symptoms encountered in cystitis, prostatitis, pyelonephritis, and urethritis.

Clinical experience extending over more than a decade, as reported in the published literature on Pyridium, has established its prompt and effective action, as well as its remarkable lack of toxicity.

More than a decade of  
service in urogenital infections

### PYRIDIUM

(Phenylazo-alpha-alpha-diamino-  
pyridine mono-hydrochloride)

Pyridium is the United States  
Registered Trade-Mark of the  
Product Manufactured by  
the Pyridium Corporation



**MERCK & CO., Inc. Manufacturing Chemists RAHWAY, N. J.**



## THROUGH THE MICROSCOPE

*continued from page 457*

Things we didn't know until now . . . . . That Norwich University (Vermont) can look at the Chinese command with the knowledge that it has been fortified with the qualities that since the days of Ethan Allen have been associated with the hills of Vermont, for no less than 16 Chinese generals are numbered among its alumni . . . . . That extensive investigations are now being conducted to determine the benefits and possible hazards involved in the contemplated use of the insecticide DDT on a large scale outdoors as part of a plan to control insect-borne diseases. Besides killing insects that carry diseases, DDT may kill other insects that are beneficial . . . . . That a one-ton electron microscope powerful enough to magnify the windpipes of mosquitoes to a size of approximately two inches has been added to the arsenal of scientific instruments for the study of cancer at the National Cancer Institute.

## CORRESPONDENCE

Home Service Dept.  
Providence Chapter,  
American Red Cross  
Providence 6, R. I.

Dear Mr. Farrell:

Many times Red Cross has been approached by a wife, mother or father of a serviceman for payment of a surgeon's bill, anesthetist's bill or a hospital bill for a private or semi-private room. In many of these situations the operation has already been performed and the bill rendered.

According to Red Cross policy payment of the hospital bill and specialist fees depends upon two things.

1) A plan made between the client and Red Cross previous to the operation.

2) A statement from the attending physician to the effect that for the sake of the patient a private room is absolutely necessary and that the case demands a particular surgeon and cannot possibly be handled through the clinic and ward.

Neither Red Cross or AER can possibly underwrite the hospital and medical profession for their service-connected families. Our National policy is that we must use local resources.

Many service-connected families have only the Government allowance as income. They cannot afford to pay for a private doctor and room in a hospital. If it is a matter of life or death, Red Cross would see to it that they had all the care needed.

Service-connected families should be told of the existing facilities in hospitals for ward care. When the situation occurs that the operation is performed and then the family realizes that they cannot pay for it, the doctor and hospital are both pushing them for the bill, it has a very bad effect on the serviceman because he is disturbed and worried about the situation at home. We realize that it is Red Cross responsibility to alleviate the situations which are a cause of his worry. However, the financial situation could be gone into by the doctor and a reasonable plan made before the operation, and a great deal of the misunderstanding could be avoided.

Very truly yours,

Mrs. Dorothy M. Calef  
Director of Home Service

## THIS SAFETY DEVICE HAD A SHORT LIFE

... Lightning rod  
umbrella, early  
19th century



## But JOHNNIE WALKER is more popular than ever

The enjoyment of Johnnie Walker is one of life's enduring pleasures. Smooth as velvet ... mellow as an old friendship ... each sip of this choice scotch whisky is a memorable occasion.

Popular Johnnie Walker can't be everywhere all the time these days. If occasionally he is "out" when you call...call again.



BORN 1820  
still going strong

# JOHNNIE WALKER

BLEND  
SCOTCH WHISKY



BLACK LABEL

Both 86.8 Proof

Canada Dry Ginger Ale, Inc.  
New York, N. Y.  
Sole Importer

BUY UNITED STATES  
WAR BONDS AND STAMPS

## OFFICERS AND ELECTED COMMITTEES

1945 - 46

*President* — JOHN F. KENNEY, M.D., Pawtucket  
*Vice President* — JOSEPH H. LADD, M.D., Exeter  
*President-Elect* — HERMAN C. PITTS, M.D., Providence  
*Secretary* — WILLIAM P. BUFFUM, M.D., Providence  
*Treasurer* — CHARLES J. ASHWORTH, M.D., Providence  
*Ass't. Secretary* — ALFRED POTTER, M.D., Providence  
*Ass't. Treasurer* — G. RAYMOND FOX, M.D., Pawtucket

*Standing Committees**Committee on Public Laws*

William H. Foley, M.D., Chairman, Providence  
 Herbert E. Harris, M.D., Providence  
 James H. Fagan, M.D., Providence  
 The President and The Secretary ex-officio

*Committee on Publication*

Harold G. Calder, M.D., Chairman, Providence  
 Augustine W. Eddy, M.D., Woonsocket  
 Paul Appleton, M.D., Providence  
 The President and The Secretary ex-officio

*Committee on Medical Education*

Jesse P. Eddy, 3rd, M.D., Chairman, Providence  
 Jacob Greenstein, M.D., Providence  
 Walter C. Weigner, M.D., Providence  
 The President and The Secretary ex-officio

*Committee on Medical Economics*

Alex. M. Burgess, M.D., Chairman, Providence  
 William M. Muncy, M.D., Providence  
 Vincent J. Ryan, M.D., Providence  
 The President and The Secretary ex-officio

*Committee on Industrial Health*

James P. Deery, M.D., Chairman, Providence  
 Charles L. Farrell, M.D., Pawtucket  
 Arthur E. Martin, M.D., Providence  
 The President and The Secretary ex-officio

*Committee on Arrangements*

Charles Bradley, M.D., Chairman, East Providence  
 James C. Callahan, M.D., Newport  
 Julianna R. Tatum, M.D., Westerly  
 Henri E. Gauthier, M.D., Woonsocket  
 Edgar S. Potter, M.D., Chepachet

*Committee on the Library*

Herbert C. Partridge, M.D., Chairman, Providence  
 Louis C. Burns, M.D., Newport  
 Meyer Saklad, M.D., Providence

*Auditors*

Russell R. Hunt, M.D., Providence  
 Philip Batchelder, M.D., Providence

*Sustained  
 Estrogenic  
 Effect...*

**Schiffelin  
 BENZESTROL**

(2, 4-di (p-hydroxyphenyl)-3-ethyl hexane)

**SCHIEFFELIN BENZESTROL TABLETS:**

0.5, 1.0, 2.0, 5.0 mg. — 50s, 100s, 1000s

**SCHIEFFELIN BENZESTROL SOLUTION:**

5.0 mg. per cc. — 10cc. vials

**SCHIEFFELIN BENZESTROL VAGINAL TABLETS:**

0.5 mg. — 100s

• Of proven value for the better management of vasomotor and nervous symptoms of the menopause, this synthetic estrogen justifies the trust which the profession places in it.

Its complete estrogenic action with minimum discomfort provides effective medication in the treatment of the menopausal syndrome and in all conditions where estrogenic therapy is indicated.

Schiffelin Benzestrol is available for oral, parenteral and local administration, enabling the physician to select the mode of administration best suited to each individual patient.

*Literature and Sample on Request*



**Schiffelin & Co.**

Pharmaceutical and Research Laboratories  
 30 COOPER SQUARE • NEW YORK 3, N.Y.

## HOUSE OF DELEGATES

### *of the*

## RHODE ISLAND MEDICAL SOCIETY

### *Report of Meeting held on May 9, 1945*

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, May 9, 1945. The meeting was called to order by President Elihu S. Wing at 8:00 P. M. The following delegates were in attendance: Drs. Rocco Abbate, Samuel Adelson, Charles Ashworth, Joseph Bellotti, William Buffum, Alex. Burgess, Bertram H. Buxton, James Callahan, Edward Cameron, B. E. Clarke, G. Ed. Crane, Frank W. Dimmitt, Walter Dufresne, Edward Famiglietti, Peter Harrington, Earl Mara, Frank Matteo, Gordon McCurdy, Anthony Migliaccio, Jesse E. Mowry, Emery Porter, Charles Southey, Stanley Sprague, J. Lincoln Turner, George Waterman, Robert Whitmarsh, and Elihu S. Wing. Also in attendance were Dr. William N. Kalcounos, President of the Pawtucket Medical Association and Dr. Herman C. Pitts, Chairman of the Committee on Medical Economics. Delegates absent were E. Bishop, H. Calder, P. P. Chase, A. D'Angleo, G. Davis, G. Dupre, A. Fox, K. Gregory, A. Jackvony, H. Jordan, J. Kenney, A. Martin, A. Potter, L. Sage, F. Taggart, J. Tatum, H. Utter.

Dr. Jesse E. Mowry, Treasurer of the Society, reviewed his Annual Report of the finances of the Society for the year 1944. Mimeographed copies of the report were distributed to each member. Dr. Mowry suggested that the Society might profitably invest some of the money of the endowment fund in Series G War Bonds. A motion was made, seconded and passed that the report be accepted and placed on file.

Dr. William P. Buffum informed the House that Dr. Mowry had asked that he be retired from the position of Treasurer which he has held for the past twenty-two years. He cited his long and faithful service and expressed the opinion that the Society would never have a more faithful servant than Dr. Mowry.

Dr. Buffum moved that the House of Delegates by a rising vote express its appreciation to Dr. Mowry for his long, faithful and efficient service as Treasurer of the Rhode Island Medical Society. The motion was unanimously carried and the House loudly applauded Dr. Mowry.

Dr. Mowry expressed his appreciation for the tribute to him and he voiced his thanks to the Society for the honor it has bestowed upon him for so many years. He stated that the consideration always shown him by the members in the fulfillment of his task as Treasurer has been one of the pleasantest memories in connection with his work.

The Secretary recommended that the Executive Secretary be asked briefly to report the highlights of the various annual reports of elected committees since he was conversant with the work that had been done by each group. Therefore Mr. Farrell reviewed the reports of the following committees: Committee on Arrangements, Dr. Edward F. Burke, Chairman; Committee on the Library, Herbert C. Partridge, Chairman; Committee on Medical Education, Dr. Jesse P. Eddy, 3rd, Chairman; Committee on Industrial Health, Dr. Charles L. Farrell,

Chairman; Committee on Public Laws, Dr. William H. Foley, Chairman; and Committee on Publication, Dr. Harold G. Calder, Chairman.

On separate motions the House voted to accept and place on file the reports of each of the above committees.

The President called attention to the fact that Dr. Charles L. Farrell of Pawtucket had resigned as Chairman of the Committee on Industrial Health and he expressed the opinion that the outstanding work that Dr. Farrell has done with that Committee merited commendation from the Society. Dr. Alex. M. Burgess moved that the House of Delegates extend to Dr. Farrell its vote of sincere appreciation for his outstanding service as Chairman of the Industrial Health Committee. The motion was seconded and unanimously passed.

Dr. Herman C. Pitts, Chairman of the Committee on Medical Economics reviewed the conferences of the Advisory Committee to the Unemployment Compensation Board relative to the State Cash Sickness Compensation plan. He stated that a meeting had been held with the Board on January 31, 1945 after the House of Delegates had instructed the Committee to make certain recommendations. He called attention that the results of that conference had been reported to each member of the House in writing. He also reported that another meeting with the Board had been held on May 9, 1945 and he reported the following conditions prevailing presently regarding the Sickness Program.

1. The General Assembly passed no amendments of the Cash Sickness Compensation Law.
2. The Unemployment Compensation Board did not introduce any amendment in the Assembly relative to the definition of sickness. The Board felt that it was the Society's right to present such legislation if it saw fit.
3. The Board states that it has been liberal in its attitude on cases brought before it on appeals, as regards defining the claimant's work, and his inability to perform it.
4. The Board requests that the House of Delegates seek some way of policing the physicians whom it feels sign certificates for patients who are really able to work. The Board will not release the names of any physicians whom it feels are not cooperating in this respect.
5. The Board states that it has taken a liberal attitude towards the acceptance of certificates dated back to initial visits. In such instances the certifying physician, and the nature of the disability reported, are carefully noted.
6. The Board states that its physicians do not communicate with any private physicians relative to the physical condition of claimants. When an appeal is taken by a claimant notice of the appeal is sent to the claimant's physician, who may either appear in person to defend the patient, or may submit written evidence to be presented by the patient.

*continued on page 465*



## ***while the iron is hot!***

- while final triumph is in sight,
- while our last remaining enemy  
stands with his back against the wall,
- while our fighting power is at its peak,
- every **EXTRA** war bond bought **NOW**  
is a ringing blow struck for victory.



FAMOUS

***Narragansett***

BREWING COMPANY  
CRANSTON, R. I.



## HOUSE OF DELEGATES MEETING

*continued from page 463*

7. The Board appoints its physicians as it determines. All such physicians will now be under civil service regulations.
8. In the absence of an Assembly amendment the Board will continue to handle pregnancy claims as in the past. It urges, however, that physicians certify such claims only when the woman is truly unable to work.
9. The Board suggests that the Advisory Committee study the present certifying forms and make such amendments as it thinks best. The Board, in turn, will adopt the amended form if possible.

After some general discussion regarding the Sickness Program Dr. Buffum moved that the Committee on Medical Economics be authorized to prepare what it considers the best certifying form for physicians under the Cash Sickness Program and to request the adoption of such form by the Unemployment Compensation Board. The motion was seconded and adopted.

General discussion ensued relative to various phases of the Cash Sickness Program. Dr. Sprague, Medical Examiner for the Cash Sickness Fund at Pawtucket, and a member of the House of Delegates, was asked to explain his version of the operation of the medical program.

After further discussion by various members of the House Dr. Sprague moved that the report submitted by Dr. Pitts for his committee be accepted as an interim report. The motion was seconded and adopted.

Dr. Migliaccio suggested that the Unemployment Compensation Board should notify any doctor whom it feels is violating the regulations regarding certification of illness, and if the doctor persists in the practice then his name should be given to the Society. The suggestion was discussed at length and finally Dr. Migliaccio moved that the House of Delegates go on record as instructing its Advisory Committee to the Unemployment Compensation Board to request that the Board notify in writing any physician who persistently violates the regulations regarding medical certification, and if the Board is unsuccessful in controlling such a problem that it then refer the names of such physicians to the Society. The motion was seconded and adopted.

Dr. Peter F. Harrington, Chairman of the Committee on Social Welfare reviewed the medical plan experiments that have been carried on by the State Department of Welfare in East Providence, Bristol and Warren. He raised several questions for discussion including what shall be the attitude towards the participation of osteopaths in the program, what shall be the attitude towards the action of the Department of Welfare in sending indigent patients eligible under this program to out-of-state clinics for treatment, and what shall be the attitude regarding the question of fees. In the discussion that ensued the Executive Secretary called attention to the fact that in Michigan the Medical Society is now carrying on a study of fee schedules throughout the state for the purpose of establishing a standard schedule of average fees to be applied for all governmental programs. He also reported briefly on the development of the new program in Maryland for the medical care of the indigent under the Department of Health and the Department of Welfare jointly.

Dr. Buffum moved that the House of Delegates accept the report of the Committee on Social Welfare and that it also request the Chairman of the Committee to bring in definite recommendations for the solution of some of the problems for consideration at the next meeting of the House. The motion was seconded and passed.

*continued on page 467*

**STOP THE URGE TO SCRATCH...  
ELIMINATE THE ITCHING...  
WITH ENZO-CAL**

➔ Prompt control of itching, which means less danger of infection from scratching, — the "aid-to-healing" and protective action of semi-colloidal calamine and zinc oxide — the mild anesthetic action of benzocaine — these all combine to make Enzo-Cal the professional favorite among antipruritics.

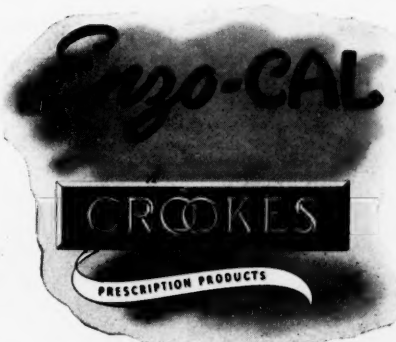
It's the favorite with patients, too, because it's a pleasing, greaseless vanishing cream — so clean and convenient to use.

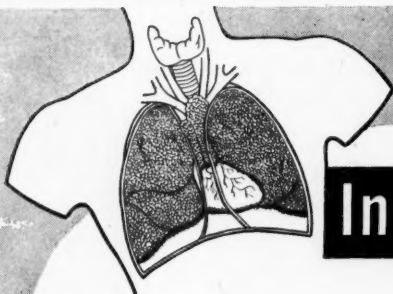
In pruritus ani, pruritus vulvae, intertrigo, eczema, diaper-rash, poison-ivy dermatitis, and skin excoriations specify Enzo-Cal.



Sample and literature to physicians on request to Crookes Laboratories, Inc., 305 East 45th Street, New York 17, N. Y.

In 2 oz. tubes and 1 lb. jars at leading pharmacies.





## In the Pneumonias

**D**URING the recent past, numerous investigations have shown that penicillin is the treatment of choice in the pneumonias (pneumococcic, streptococcic, staphylococcic).<sup>\*</sup> Penicillin is virtually nontoxic, even in the massive dosages at times required. Its efficacy apparently is the same against sulfonamide-resistant and nonresistant organisms of the groups named. Even in advanced stages of the disease, in the presence of serious complications, penicillin usually proves a life-saving measure.

Since penicillin has become available in quantities that may well be adequate for all needs, it merits being the physician's first thought with every pneumonia patient.

<sup>\*</sup>Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, Pennsylvania M. J. 48:119 (Nov.) 1944.

McBryde, A.: Hemolytic Staphylococcus Pneumonia in Early Infancy; Response to Penicillin Therapy, Am. J. Dis. Child. 68:271 (Oct.) 1944.

Stainsby, W. J., Chairman, Commission for the Study of Pneumonia Control of the Medical Society of the State of Pennsylvania: Up-to-Date Facts on Pneumonia, Pennsylvania M. J. 48:266 (Dec.) 1944.

Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:272 (July-Aug.) 1944.

## PENICILLIN-C.S.C.

Penicillin-C.S.C. deserves the physician's preference not only in the pneumonias, but whenever penicillin therapy is indicated. Rigid laboratory control in its manufacture, and bacteriologic and biologic assays, safeguard its potency, sterility, nontoxicity, and freedom from pyrogens. The state of purification reached in Penicillin-C.S.C. is indicated by the notably small amount of substance required to present 100,000 Oxford Units. Because of this purity, incidence of the undesirable reactions, attributed by many investigators to inadequate purification, is greatly reduced.

PHARMACEUTICAL DIVISION

**COMMERCIAL SOLVENTS CORPORATION**

17 East 42nd Street



New York 17, N. Y.



Penicillin-C.S.C. stands accepted by the Council on Pharmacy and Chemistry of the American Medical Association.



## HOUSE OF DELEGATES MEETING

*continued from page 465*

The Secretary read a communication from the Rhode Island Chapter of the American Red Cross relative to authorization for the payment of fees for surgeons operating upon the relatives of service men. No action was taken.

The Secretary presented the slate of officers recommended by the Council to serve the Society during the year 1945-46 with one change from the slate mimeographed and distributed to the members. The change would make Dr. James P. Deery Chairman of the Committee on Industrial Health instead of Dr. Farrell. Dr. Belliotti moved that the House adopt the slate of nominations as recommended by the Council. Dr. Cameron seconded the motion and it was unanimously adopted.

The Secretary reported motions from the Council to the House of Delegates as follows:

1. That the Trustees of the Fiske Fund file a complete report relative to the Fund to the House of Delegates in May, and that said report be transmitted to the Secretary of the Society at least ten days prior to the House of Delegates meeting so that copies may be furnished to each member of the House.

Dr. Wing, Chairman of the Board of Trustees, reported that the Board had conferred with Dr. Wilfred Pickles who has intimate knowledge of the operation of the Fiske Fund, having served as its Secretary for years, and upon his advice the Board asks that the Fund be left as it is and not transferred to the general Society funds.

2. That the By-Laws be amended so that the ex-vice presidents in order beginning with the most recent shall serve in place of any of the five most recent ex-presidents who are unable to attend a meeting of the Council.

Dr. Whitmarsh moved adoption and Dr. Abbate seconded. The President called for a discussion and he remarked that the Executive Secretary had noted a pointed issue regarding this resolution. Mr. Farrell stated that under the motion there would be only one ex-president available and he wondered if that would meet the requirements of the House. He suggested the possibility of the election of a councillor at large. Dr. Dufresne suggested that each district society elect a councillor at large who might attend the Council meeting when the elected councillor is unable to be present. These suggestions received support from the House and Dr. Whitmarsh withdrew his motion to adopt the original recommendation of the House of Delegates and Dr. Abbate withdrew his second. The Secretary conferred with Dr. Mara and reported a recommended resolution as follows:

"Resolved that Article VII, Section 2 of the By-Laws titled Composition be amended to read as follows:

"The Council shall consist of the Councillors elected by the component societies, the five most recent living past presidents of the Society, the President, the President-Elect, the Vice-President, the Secretary, the Assistant Secretary, the Treasurer, and the Assistant Treasurer.

"An Elected alternate Councillor may serve in the absence of the Councillor or past President from his Component Society."

The amended resolution was seconded and unanimously adopted.

Dr. Wing discussed the Detroit Conference of Medical Society Presidents, and he read communications from the President and the Executive Vice President of the New England Council. He asked for action by the House of Delegates on the suggestion of the Michigan Medical

Society for a drafting panel to cooperate with similar committees of other state societies in furthering public relations and in making known local desires regarding national health legislation.

Dr. Peter F. Harrington moved that a Committee on Public Relations and Medical Care be appointed by the President to carry on discussions with similar committees of other states on programs such as outlined by the Public Relations Conference sponsored by the Michigan State Medical Society. The motion was seconded and passed.

Dr. Edward S. Cameron moved that the proposal for a commercial radio program in conjunction with the Michigan State Medical Society and the other state medical societies represented at the Detroit Conference should be laid on the table.

Dr. Alex. M. Burgess moved that the Rhode Island Medical Society take leadership in forming a New England Medical Council of the medical societies of the Northeast. The motion was seconded and passed.

The President spoke briefly regarding the question of deferment of medical students and asked if the House desired to express an opinion regarding the Ellender Bill now before Congress. A motion was made, seconded and passed that the House of Delegates approve the principles laid down by the Ellender Bill which is now before the Congress of the United States.

The meeting adjourned at 11:30 P. M.

Respectfully submitted,

WILLIAM P. BUFFUM, M.D., *Secretary*

IN MOUNT PLEASANT IT'S . . .

## Butterfield's DRUG STORES

Corner Chalkstone & Academy Aves.  
WEST 4575

Corner Smith & Chalkstone Aves.  
DEXTER 0823

IN OLNEYVILLE IT'S . . .

## McCAFFREY INC.

### Druggists

19 OLNEYVILLE SQUARE  
PROVIDENCE 9, R. I.

# How Long is a good night's sleep?



*Four? Eight? Sixteen hours? Eight hours most closely approximate the requirements for normal physiological recuperation. Ipral functions within this range. Given one hour before retiring, Ipral will carry the patient through a full night's sleep, unlike the shorter-acting hyp-*

*notics whose effects wear off quickly. Ipral will then permit the patient to wake up in the morning generally calm and refreshed; free from the lassitude of longer-acting hypnotics. Ipral Calcium (calcium ethylisopropyl barbiturate Squibb) in 2-grain unidentifiable tablets.*

## SQUIBB

*Ipral*  
TRADEMARK CALCIUM

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858



## ANNUAL REPORT OF THE SECRETARY

During the past year the membership of the Society has increased. When we compare the membership to that of five years ago the picture is very striking, as will be seen in the following columns:

	1940	1945
Total Membership .....	489	709
Paying Membership .....	448	465
Members in Armed Forces .....		187

During the past year the annual increase of business has continued. The six bimonthly meetings of the Council have been long and arduous and the three regular and one special meeting of the House of Delegates have been crowded with business. If the business of the Society is to continue and if it is to be properly handled we should develop some new technics. Probably the Council or some committee of the Council should meet once a month to see that the committee work is properly apportioned, that it is done and that the agenda for the meetings are arranged to the best advantage.

During the year the Society has functioned well due to the loyalty of the members of the Council and the House of Delegates, to the efforts of our Executive Secretary and to the enormous amount of detailed work which has been done by our President. If this standard of work is to be continued our technic of operating will need to be improved.

The business coming before the Society is of constantly increasing difficulty and complexity. We need the wisdom

of Solomon to know how to act. Under these circumstances it is highly important that our component societies send to the House of Delegates and to the Council the members they want to represent them and members who will attend the meetings. It would seem clear that representatives should not be reelected over a long period of time as a matter of courtesy but only if their services warrant it.

The business transacted by the Executive Office is very great. The routine business of the Society, the carrying on of the committee work and the management of the JOURNAL are too much for the present staff. I suggest that the Council consider having another stenographer to assist Mr. Farrell.

The procedure of the House of Delegates could be made more efficient. I suggest that we continue and enlarge the custom of having questions referred to committees. The committee report should contain definite recommendations. If action is to be taken the report should conclude with a motion or resolution which covers the desired action. This motion could be passed immediately or if controversial would give the House something definite to discuss.

Following the line of thought of my last suggestion, I recommend that no action be taken on these suggestions at the present time and that this report be accepted and placed on file.

Respectfully submitted,

WM. P. BUFFUM, Secretary



### *Medical Secretaries . . .*

- Edgewood Medical Secretaries are skilled in laboratory technique, medical stenography and accounting.

*Interested professional men should phone or write  
the College PLACEMENT OFFICE*

## Edgewood Secretarial School

*founded 1924*

198 Armington Street      Edgewood 5, Rhode Island

ASSOCIATE MEMBER - AMERICAN ASSOCIATION OF JUNIOR COLLEGES

# Penicillin DOSAGE TABLE\*

INDICATIONS	INITIAL DOSE (UNITS)	CONTINUING DOSAGE (UNITS)	UNITS IN 24 HR.	REMARKS
<b>Serious Infections</b> (staphylococcus, clostridium, hemolytic streptococcus, anaerobic streptococcus, pneumococcus, gonococcus, anthrax, meningococcus) Adults and children	15,000 to 20,000	(a) Intravenous drip: 2000 to 5000 every hr.	40,000 to 120,000 or more	(a) Dissolve ½ of 24 hr. dose in 1 liter (1000 cc.) normal saline; let drip at 30 to 40 drops per minute.
		or (b) Intramuscularly: 10,000 to 20,000 every 3 or 4 hr.	40,000 to 120,000 or more	(b) Concentration: 5000 U. per cc. normal saline.
		or (c) Intramuscular drip	40,000 to 120,000 or more	(c) Total daily dose in 250 cc. normal saline.
Infants	5000 to 10,000	3000 to 10,000 intramuscularly every 3 hr.	20,000 to 40,000 or more	Each dose in 1 or 2 cc. of normal saline.
<b>Chronically infected</b> compound injuries, osteomyelitis, etc. Adults and children	5000 to 10,000	10,000 every 2 hr. or 20,000 every 4 hr. intramuscularly or intravenously. Larger doses may be necessary at times.	40,000 to 120,000 or more	Concentration for intramuscular inj.: 5000 U. per cc. normal saline. For intravenous inj.: 1000 to 5000 U. per cc. Supplement with local treatment.
<b>Gonorrhea</b>		20,000 every 3 hr. intramuscularly for 5 doses	100,000	Results of treatment should be controlled by culture of exudate.
<b>Empyema</b> Adults and children		30,000 to 40,000 once or twice daily into empyema cavity	30,000 to 80,000	Dissolve in 20 to 40 cc. normal saline and inject into empyema cavity after aspiration of pus.
<b>Meningitis</b> Adults and children		10,000 once or twice daily into subarachnoid space or intracisternally	10,000 to 20,000	Concentration: 1000 U. per cc. normal saline.
<b>Bacterial Endocarditis</b> Adults and children	25,000 to 40,000	25,000 to 40,000 every 3 hr. intramuscularly	200,000 to 300,000	Continuous treatment for 3 weeks or longer. In a few cases the intravenous drip is more advantageous.

\*Based upon recommendations by Chester S. Keefer, War Production Board Penicillin Leaflet, Apr. 1, 1945; and by Wallace E. Herrell and Roger L. J. Kennedy, *Journal of Pediatrics*, 25:505, Dec., 1944.

● Write for pocket size copies of this Dosage Table

Penicillin Sodium-Winthrop is available in vials (with rubber diaphragm stopper) of 100,000 Oxford Units.



WINTHROP CHEMICAL COMPANY, INC.

*Pharmaceuticals of merit for the physician*

NEW YORK 13, N. Y.

WINDSOR, ONT.